FSAs, Tax Credits Offer Health Care Security — page 6

HIMSS Exhibitors See page 19!

Health Care News

©2001 The Heartland Institute | The Monthly Newspaper for Health Care Reform | Vol. 1 No. 9 ~ December 2001

2 September 11 and Mental Health
4 Is Prior Authorization Worth It?
5 NGA Touts Rx Pools
7 MSAs: Windfall for All
8 Year-End State Roundup
14 Responding to Bioterrorism

Maine Debates Single-Payer Health Care

Voters narrowly approve single-payer plan in non-binding ballot measure

BY CONRAD F. MEIER

Voters in Portland, Maine were asked in November if they wanted government-run health care. Nearly 52 percent (7,024) cast ballots in support of the non-binding resolution, while 48 percent (6,494) rejected it.

Last year, Maine lawmakers had rejected a proposal to create a $3.4 billion single-payer health care system, agreeing instead to form a panel to study the issue. The panel is expected to report its findings by March 2002.

November's vote, while not a strong endorsement of government-run health care, will likely influence talks about the single-payer proposal when lawmakers reconvene in January. House Speaker Michael Saxl (D-Portland) told fellow supporters of the proposal, "If we are unsuccessful here in Portland, that will send a gigantic message to the rest of the state."

Greg Scandlen, senior fellow in health policy at the National Center for Policy Analysis (NCPA) and assistant editor of *Health Care News*, disagreed. "The legislature is not likely to take it as a ringing endorsement," Scandlen said. "In fact, there is a fair amount of resentment of Portland by the rest of the state, and even if it had won big, it would probably not make a big difference."

Dueling Coalitions

The Campaign for Universal Health Care—driven by the Labor Party (a five-year-old political party with chapters in 26 states), Maine People's Alliance, Maine AFL-CIO, Portland Democratic Committee, Portland Independent Greens, and Consumers for Affordable Health Care—backs a single-payer system.

Its efforts are opposed by Citizens for Sensible Health Care Choices—a coalition funded by Anthem Blue Cross/Blue Shield of Maine and members of the Libertarian Party. The group rolled out three television advertisements on network and cable stations to defeat the ballot measure, calling it "a publicity stunt."

Daryn Demeritt, a Pierce Atwood consultant hired to lead the anti-resolution campaign, told the *Portland Press-Herald*, "We know that this is just an attempt to get the camel's nose under the tent to enact a single-payer system on a statewide level. This is a tremendous battle."

The Campaign for Universal Health Care says a single-payer system would provide less-expensive health care by eliminating the middle-man expense of insurance companies. Citizens for Sensible Health Care Choices disagrees, noting government red tape, rationing of services, and under-funding would ham-

MAINE continued on page 17

British Prime Minister Tony Blair smiles as he addresses staff and patients at the Central Middlesex Hospital in London. Photo: Adrian Dennis/Reuters

Health Care in England: Not Your Cup of Tea

Part One in a series

BY CONRAD F. MEIER

It is one thing to read the U.S. media's meager reporting on the critical condition of Britain's health care system. It is quite another to experience first-hand how those who depend on their government for medical care have been trapped in a failing single-payer health care arrangement.

The single-payer approach, deemed "free health care" by its beneficiaries and proponents, has led to limitless and often irresponsible demands on Britain's National Health Service (NHS), without providing a funding mechanism

ENGLAND continued on page 12

Free-Market Health Insurance Flourishes Online

BY HEATHER WILLIAMS

Small businesses are the perfect online insurance customer: wired and Internet-savvy. But only recently have 20 million American small businesses gotten the online attention they deserve, with several new Web sites offering online quotes and applications for small-group health insurance.

Some sites act as brokers, while others put you in touch with a broker in your area. Site features run the gamut, from bare-bones quoting services offering no insurance advice, to sites that bill themselves as "benefit portals" and provide reams of small-business benefits advice.

"Our sweet spot is around the 20-person company," says Billy Dukes, marketing director at the benefits site Firstdoor.com, with a home page that states it provides "a one-stop solution for the employee benefits and human resource management needs of small businesses."

"They're big enough to where they're having to deal with the issues of employee management and benefits, but small enough that they don't have one person dedicated to human resources decision-making. We try to create the knowledge and tools that can help them make a better insurance decision," Dukes says.

Making it Work

At health insurance sites, the small employer can obtain an aggregation of group health quotes. He or she can select quotes based on deductibles and other plan features before ever contacting a broker.

Buying a health plan online, however, doesn't always offer a better deal on premiums, because of strict state regulations and mandates impacting premium levels. And

ONLINE continued on page 15

INSIDE HEALTHCARENEWS

3 The Pulse
10 Private Insurance Available
12 Drugs by Lottery?
14 Anthrax 101
16 The Galen Report
17 Trouble for TennCare

MY TURN

AN EDITORIAL BY CONRAD MEIER

Socialized Medicine at the Back Door p.18

The Heartland Institute
19 South LaSalle #903
Chicago, IL 60603

PRESORTED STANDARD
US POSTAGE PAID
BEAVER DAM, WI
PERMIT NO. 412

LICENSED TO UNZ.ORG
ELECTRONIC REPRODUCTION PROHIBITED

Health Care News

EDITORIAL OFFICES
The Heartland Institute
19 South LaSalle
Suite 903
Chicago, Illinois 60603
312/377-4000 voice • 312/377-5000 fax
email think@heartland.org

PRESIDENT
Joseph L. Bast

PUBLISHER
Nikki Saret

EDITOR
Diane Carol Bast

MANAGING EDITOR
Conrad F. Meier

ASSISTANT EDITORS
Greg Scandlen
Merrill Matthews

CONTRIBUTING EDITORS
Twila Brase, Bob Corkins
Dewey L. Crepeau, Dr. Miguel A. Faria
Tom Miller, Gerry Smedinghoff
Grace-Marie Turner

CARTOONISTS
Mike Shelton
Chuck Asay

DESIGN AND PRODUCTION
Kevin Fitzgerald
Jennifer Beranek

ADVERTISING MANAGER
Nikki Saret

CIRCULATION MANAGER
Latreece Vankinscott

BOARD OF DIRECTORS
Joseph Bast, Robert Buford, Paul Fisher
James Fitzgerald, Dan Hales
William Higginson, James L. Johnston
Roy E. Marden, David H. Padden
Frank Resnik, Leslie Rose
Robert Russell, John Skorburg,
Herbert J. Walberg Ph.D., Lee H. Walker

Health Care News is published 12 times per year by The Heartland Institute. Subscriptions are free to U.S residents and $24 per year for foreign residents. Order online at www.heartland.org. Heartland is a nonprofit and nonpartisan public policy research organization serving the nation's federal and state elected officials, journalists, Heartland Members, and other opinion leaders. Its activities are tax-exempt under Section 501(c)(3) of the Internal Revenue Code.

© 2001 The Heartland Institute. Nothing in this issue of Health Care News should be construed as reflecting the views of The Heartland Institute, nor as an attempt to aid or hinder the passage of any legislation.

Are Insurers Prepared for the Mental Health Fallout?

BY VICKI LANKARGE

Throw out all the studies on the psychological effects of a national disaster that were conducted prior to September 11, 2001, says child psychiatrist Dr. Barry Herman, an executive board member of the National Coalition for Mental Health Professionals and Consumers.

"Get braced for the unknowable," warns Herman. "Mental health professionals, especially those who work with children, should be prepared to deal with an epidemic of significant stress reactions."

Health insurers are already noticing an increase in the number of requests they normally receive for mental health services, particularly in New York and New Jersey, according to Erin Somers, a spokesperson for Magellan Health Services, a managed behavioral health care company. In response, companies like Magellan have made their employee assistance counseling and "critical incident" stress management programs available to help employees and their families deal with the terrorist attacks.

Are We Prepared?

But are insurers really prepared for the mental health fallout from September 11? Karen Shore, founder and past president of the National Coalition for Mental Health Professionals and Consumers, doesn't believe so. "People had a hard time getting mental health treatment *before* September 11," she says.

> **"People should take comfort in knowing their emotional reactions to the tragedy are shared by many others . . ."**

With its phantom networks (an HMO network that lists doctors who are not taking new patients) and treatment limits, Shore says "the managed care system is an affront to mental health patients." She warns the terrorist attacks are not likely to change that any time soon.

But health plans are sensitive to the criticisms being leveled at them, says Leslie Moran, spokesperson for the New York Health Plan Association. "Health plans are extremely sensitive to the needs of the public right now," she says. "They're making an extra effort to avoid making it difficult for their members who need help."

Nation Was Raped

According to Herman, there is no precedent for this kind of disaster—which is precisely why it's impossible to predict how the psychological aftershocks may evolve. "Time is usually a healer," he says, "but if more bombs go off, it will just revivify the experience."

Herman says that following the attacks, people exhibited some of the same reactions as victims of rape, including hypervigilance (increased awareness of one's surroundings), depression, and sleeplessness. "It's the classic rape response," says Herman. "This was the rape of our country."

According to Dr. Robin Dea, chairman of the chiefs of psychiatry for Northern California Kaiser Permanente, the attacks were certainly a personal violation of Americans' sense of security and safety. "We have been violated in the same way that we were violated at Pearl Harbor, or when John F. Kennedy was assassinated," she says. "It was the very shock of it happening on our own soil."

The initial numbers have been sobering. Shore says an estimated 15,000 children have lost one or both parents in the attacks. According to the Pew Charitable Trust, a nonprofit public policy philanthropy, in the wake of the terrorist attacks:

- Seven out of 10 Americans have felt depressed.
- Nearly one in two have had trouble concentrating.
- One in three have had difficulty sleeping.
- One-fifth knew someone who was killed, injured, or is still missing from the attacks, or have a friend or relative who does.

Make no mistake about it, says Shore, "there will be more substance abuse, gambling, and other addictive behaviors as people try to anesthetize the pain. In particular, people in New York City are still going to funerals—sometimes dozens of them. You can't keep doing that and not be affected."

Private Sector Responds

Many health insurers, particularly those in New York and New Jersey, have responded by loosening treatment caps. According to Moran, Oxford Health Plan has extended by 10 the number of mental health visits a member may make by December 31, 2001.

But Shore says she is concerned about the long term. "There is a great outpouring of people offering free services right now, but people are still in shock," she says. "What happens down the road? We're still seeing Vietnam vets coming into VA hospitals for the very first time to get treatment for post-traumatic stress disorder. It's what—35 or 40 years later?"

In the wake of the terrorist attacks, Dr. Dea did a quick survey of five of Kaiser Permanente's behavioral health care facilities in northern California. She says the facilities all reported receiving an increase in the number of telephone calls from their members who work in financial services and the airline industry. "There were also reports that existing patients would call and, before they could address whatever was the usual topic of conversation, they would want to tell the therapist what effect the tragedy was having on them. A lot of it was, 'I was generally stable, but this thing has really thrown me for a loop.'"

Time Heals

Dea says the first week after the attack the volume of calls coming in was "barely a trickle." She says it picked up the second week, but "quieted down again" by the third week. According to Dea, Kaiser held mental health help meetings two or three times a week after the Bay Bridge earthquake in 1989 and had planned to do the same after this disaster, "but the demand hasn't been there this time." Dea says she believes people are using other outlets for talking about their concerns, such as friends, employee assistance programs, or clergy.

For more information…

WWW See the article at **www.insure.com**, "Getting mental health help for kids in crisis is tricky."

"As a culture, we're already seeing things getting back to normal," Dea says, particularly for those who live outside the areas that were attacked. "We're already seeing airplane traffic pick up."

Dea says people should take comfort in knowing their emotional reactions to the tragedy are shared by many others and are, for the most part, what mental health experts would expect. "For the first three to five days, everyone was numb," she says. "Then we were all glued to our TVs. It was all we talked about. By the third week, we were saying, 'I have to get away from this. I have to get out, go to a movie.'"

Dea suggests that if you aren't one of the people who lost a loved one or know someone who did and "you're still feeling numb, it might be worthwhile to have a [mental health] evaluation."

Vicki Lankarge writes for insure.com, the Consumer Insurance Guide.

LICENSED TO UNZ.ORG
ELECTRONIC REPRODUCTION PROHIBITED

The Pulse

Free-market health care reform in the news

BY GREG SCANDLEN

I was in Maine recently debating single-payer with John Ross, MD, president of Physicians for a National Health Program. The Maine legislature has established a commission to recommend whether and how to adopt single-payer in that state, and there was a referendum on the ballot in Portland asking the City Council to do everything possible to influence this commission to favor the state take-over of health care. The debate was sponsored by the School of Social Work at the University of Southern Maine, so you can imagine what the crowd was like! (See related story on page 1.)

PNHP's Extreme Rhetoric

The debate was instructive for learning how ideological the single-payer crowd is. Most of us avoid using the term "socialist" to describe these folks, because it seems inflammatory. But after experiencing Dr. Ross, and studying the PNHP Web site, I would say "socialist" is too mild a term. These people are clearly Marxist in ideology, and don't mind using extremist terminology.

Ross, for instance, kept equating "for-profit" with "right-wing." There is a quotation at the head of the PNHP Web site that reads, "Rats and roaches live by competition under the laws of supply and demand. It is the privilege of human beings to live under the laws of justice and mercy."

A presentation posted on the site by Karen Palmer includes this sentiment: "Whether we like it or not, we are going to have to deal with the persistence of the narrow vision of middle-class politics. Vincente Navarro says that the majority opinion of national health insurance has everything to do with repression and coercion by the capitalist corporate dominant class."

Maybe it's time to start calling a spade a spade.

Source: http://pnhp.org

MSA Paper Published by NCPA

I have just written a new paper on Medical Savings Accounts for NCPA. In it I try to debunk some of the myths that have been parroted about the concept, and explain how MSAs and other consumer-driven approaches to health care financing are superior to managed care. I also have fun recalling some of the more outlandish quotes from Ted Kennedy, Gail Shearer, etc., who promise the end of civilization if MSAs should be enacted.

Source: http://www.ncpa.org/pub/bg/bg157/

Chicago Tribune Likes MSAs

The *Chicago Tribune* suggests MSAs are a good solution for small employers facing large premium increases, many of whose workers can't afford any more cost-shifting. The article quotes Allen Wishner of Flexible Benefit Service Corp. to explain the concept.

Source: http://chicagotribune.com/ Unfortunately, the *Tribune* charges for articles even when they are only a day old. If you still want it, search in the archives for recent mentions of medical savings accounts. The article appeared on November 1, 2001.

Consumer-Driven Health Care in Minnesota

Minnesota employers are also looking at MSAs and other consumer-driven health benefits, according to an article in the *St. Paul Pioneer Press*. The article cites one small employer who has seen 50 percent rate increases in the past two years and now is looking at another 32 percent hike for next year.

Source: http://www.pioneerplanet.com/sevendays/thu/news/ docs/168704.htm

New York Looking at Defined Contribution

Crain's New York Business quotes one New York employer who is experiencing a rate hike of 20 percent on top of a 25 percent increase last year. "We can't go on like this," he says, especially with a slowing economy.

The article says some employers are raising copays and premium costs for workers, but others are "rethinking health care coverage altogether, opting for more consumer-driven plans that put a fixed amount of dollars into employee accounts and encourage workers to play a more active role in keeping their medical costs down."

Source: http://www.crainsny.com There is a charge for accessing full-text articles. This one is by Samantha Marshall and is headlined, "Employers Run for Cover From Rising Insurance," October 22, 2001.

Seattle Looking at Defined Contribution, Too

Across the continent in Seattle, employers are making similar moves, according to Peter Neurath in the *Puget Sound Business Journal*. He writes, "New high-deductible health insurance policies are coming to market—as employers struggle with ever-higher premiums for employee health coverage . . ."

The article quotes Dr. Vern Cherewatenko as saying, "Insure for the big stuff, pay cash for the small stuff, just like you do with your car."

Source: http://seattle.bcentral.com/seattle/stories/2001/11/05/focus3.html

---

Mainstream Insurers Moving to D-C

Employee Benefit News is staying on top of this trend. Karen Lee writes in the November 1, 2001 issue that "mainstream insurers" are now rolling out products to compete with the newer companies like Sageo, Lumenos, and DefinityHealth. The article emphasizes Aetna's new product, but adds that United Healthcare and Humana are about to offer similar consumer-driven products.

Lee also mentions a recent Watson Wyatt survey of 10,000 employees, which she says found that less than half are satisfied with their current health plans, and 39 percent said they want their employers to contribute a fixed amount, "even if it means workers would have to find their own health plans."

Source: This article doesn't appear to be included on *EBN*'s Web site, but it was published in the November 1 edition, headlined, "Employers, Employees at Odds Over Fixes." Contact Karen Lee through the EBN Web site http://www.benefitnews.com for a copy.

Employees Like Defined Contribution

Lee writes another article for *EBN* that expands on the Watson Wyatt results and also looks at a Kaiser Family Foundation (KFF) survey that found "40% of consumers insist that managed care plans actually do a 'bad job' serving participants."

She notes that KFF is still insisting on a Patients' Bill of Rights, even though the survey indicates consumers are willing to compromise on that issue. She quotes Bob Blendon as saying that, while the public supports the idea, it is not a top priority and they are not focused on the details. She adds, "employees have another solution to their health care woes: a defined contribution plan."

Source: http://www.benefitnews.com/subscriber/Article.cfm?id=37880418

VEBAs May Be Answer, Says Wallach

The biggest limitation on moving to defined contribution and personal health accounts is not market interest, but the regulatory environment, including the federal tax code, HIPAA, ERISA, and state insurance laws. These problems can be overcome by using VEBAs (Voluntary Employee Benefit Associations, Section 501(c)(9) plans).

VEBAs are especially attractive for public employers, retiree benefits, and multiple employer situations. Lance Wallach has an article in *Employee Benefit News* explaining some of these benefits.

Source: http://www.benefitnews.com/subscriber/Article.cfm?id=37880416

AMNews Reports on Wye River Study

AMNews includes a nice write-up of the Wye River press conference in the current issue. Staff writer Amy Snow Landa lists the groups that have sponsored the Wye research, and adds comments from Mark McClellan of the President's Council of Economic Advisors. McClellan says the Wye River paper "fits in very well with our overall direction." The article highlights the need for an FSA rollover.

Source: http://www.ama-assn.org/sci-pubs/amnews/pick_01/gvsa1105.htm

---

Greg Scandlen is senior fellow in health policy at the National Center for Policy Analysis in Dallas, Texas. To sign up for his free weekly e-newsletter, Scandlen's Health Policy Comments, log on to www.ncpa.org/sub/. Scandlen can be contacted by email at GMScandlen@aol.com.

LICENSED TO UNZ.ORG
ELECTRONIC REPRODUCTION PROHIBITED

Prior Authorization: Worth What it Costs?

Prior authorization is expensive and raises liability issues

BY DEBI REISSMAN, PHARM.D.

Prior authorization, like many pharmacy management processes, can be used to improve the quality of medical care delivered to patients. This is true when it is used to verify quality issues for continued treatment, such as assuring that laboratory tests have been performed to monitor for potential adverse reactions, or that appropriate dose adjustments have been made for elderly or pediatric populations.

However, requiring prior authorization on every new, expensive pharmaceutical coming to market may cost a health plan more in labor and potential liability than if it had just covered the drug from the beginning.

Rife with Problems

For the health plan, prior authorization is labor-intensive and expensive. Many plans quote costs of $10 to $25 per authorization request, with more than 80 percent of the requests approved.

Physicians see prior authorization as a threat to their diagnostic and treatment authority. Patients consider it interference with their right to receive the best medical care available. Pharmaceutical companies believe prior authorization keeps their products from patients who might benefit from them.

Costs vs. Savings

Much effort and energy has been expended by these players arguing the finer points of prior authorization: which products to include, what criteria to use, when to approve, when to deny. Lately, those discussions are also taking place within state and federal legislative bodies and regulatory agencies. As a result, health plans may have thrust upon them significant changes in the rules that govern prior authorization management.

A review of pending and approved legislation suggests states may force health plans to allow patients to obtain second opinions to overturn prior authorization denials. Time limits may be set for prior authorization reviews and decisions, so health care is not unreasonably delayed.

> **"What the regulations do is create a system in which each of us is required to exercise, repeatedly and against our own will, this right to permit others to use information about us."**

Legislation may require that prior authorization denials be sent in writing to the patient and physician; that denials be issued by a physician rather than a pharmacist or technician; and that appealed denials be reviewed by a physician other than the original reviewer.

All of these processes will add time and expense to the prior authorization process—even though the majority of prior authorization requests are eventually approved. It thus becomes questionable if the savings actually offset the expenses incurred.

Liability Issue

Many newer pharmaceutical agents, such as cyclooxygenase-2 inhibitors and non-sedating antihistamines, cost more but may be safer than older agents that plans want patients to use first. Newer agents, such as those used in the treatment of rheumatoid arthritis, may also be more efficacious in minimizing disease progression or complications.

How often are the products with prior authorization status reviewed by the health plan's medical/legal department, or by outside legal counsel, to assess health plan liability in denying a potentially "better" treatment that costs more? What happens when a patient experiences a serious medical complication that may have been avoided if he or she hadn't been required to use the more-established drug?

Health Plans Seek Solutions

The three-tier formulary used by health plans today was designed in part to minimize the administrative costs and patient confusion associated with prior authorization. The three-tier formulary essentially exchanges the punitive prior authorization process for much higher co-payments or cost-sharing for some drugs. Nevertheless, many plans are now adding prior authorization criteria to even their top-tier agents—in addition to charging the higher co-payment.

Browsing the pharmacy Web sites of major health plans or typing the keyword "prior authorization" into a Web browser identifies a seemingly endless list of drugs requiring such authorization and the various protocols needed to obtain approval. Clearly, the prior authorization requirement is not only alive and well, but prospering.

So where do we go from here?

Reform Ideas

It makes little sense to further complicate the pharmacy benefit with additional tiers and prior authorization criteria. Doing so could result in the opposite of reform: plans with more products requiring prior authorization than not. At the same time, payers cannot afford the cost of unlimited and unmanaged medical care.

Rather than focusing on fighting with physicians over which drug to prescribe, efforts might be better spent identifying the highest-risk patients; improving compliance to therapy and reaching treatment goals; looking for quality care issues, such as patients with potential drug interactions, adverse drug events, and polypharmacy; and focusing energies on inappropriate treatment areas, such as antibiotic use in viral infections.

It would be interesting for a managed care plan to study the cost of managing prior authorization, including all medical and legal costs for both the plan and patients involved, and the cost of the same system without the authorization process.

Any takers?

Dr. Debi Reissman is president of Rxperts Inc., a managed care consulting firm in Irvine, California. You can visit the Rxperts Web site at www.rxperts.net. *This article is derived from one that first appeared in* Drug Benefit Trends, *12(10):22,24, 2000.* *©Cliggott Publishing Co., a division of SCP/Cliggott Communications, Inc.*

PolicyBot®

PolicyBot™ gives you free, instant access to the complete texts of over 7,000 studies, reports, articles, and other documents on today's hottest public policy issues.

LICENSED TO UNZ.ORG
ELECTRONIC REPRODUCTION PROHIBITED

Governors Group Touts Rx Purchasing Pools

BY CHRISTINE LAPAILLE

The National Governors Association (NGA) announced on October 24 the release of a report on pharmaceutical purchasing pools, touted by West Virginia Governor Bob Wise during a media blitz he used to launch the Southern States Coalition's pharmacy working group.

The NGA report, issued by the Health Policy Studies Division of the group's Center for Best Practices, outlines state efforts to control escalating prescription drug costs, including the development of purchasing cooperatives that enable participants to negotiate lower pharmaceutical prices, secure greater discounts and rebates with manufacturers, and improve quality of care due to the alliances' increased market power.

Focusing on two interstate purchasing pools—the Southern States Coalition and the New England Tri-State Prescription Coalition—and the intrastate efforts of Georgia, Massachusetts, and Texas, the report offers background and analysis of the development, structure, and goals of the various purchasing pools and their organizational status.

Southern States Coalition Issues RFP

The NGA report was released less than one week after the West Virginia Public Employees Insurance Agency issued a request for proposal for a multistate pharmaceutical purchasing effort.

The new Southern States Coalition purchasing pool will serve state employees in Louisiana, Mississippi, Missouri, New Mexico, South Carolina, and West Virginia. The coalition creates a purchasing pool of approximately 1.4 million people, with at least eight additional states expressing interest in participating in the group.

"We've taken a unique approach in the development of the Southern States Coalition," said West Virginia Governor Wise. "We found that with the dramatic increases in pharmaceutical spending, we could best serve our constituents by partnering with states that share a similar view about health care."

The RFP issued on behalf of the coalition differs from traditional pharmacy benefit manager (PBM) arrangements in its reduction of rebate levels and the maximization of administrative fees paid to the managing group. This, explained Wise, "eliminates increased profits for the PBM should more people get sick and our expenditures increase."

New England Unites

The New England Tri-State Prescription Coalition unites Maine, New Hampshire, and Vermont in an effort to address rising prescription drug costs for the states' uninsured, under-insured, and those covered by government programs. The plan went into effect November 1. The coalition hopes to enhance the availability of prescription drugs for its beneficiaries, while also saving between 10 and 15 percent of the three states' combined $387 million annual Medicaid bill.

While such interstate programs offer great potential for negotiating drug discounts, they are not the only option available to states. In fall 2000, Georgia launched a multi-program purchasing cooperative that combined the state employees insurance plan, higher education health insurance programs, Georgia Medicaid, and the children's health insurance program, PeachCare for Kids.

Similarly, the FY 2000 budget for the Commonwealth of Massachusetts created a bulk purchasing program aimed at saving approximately $200 million by grouping into one pool an estimated 1.6 million senior pharmacy assistance participants, Medicare and Medicaid enrollees, state workers, and uninsured and under-insured individuals. Implementation of the plan has not yet begun.

In June 2001, Texas created a multi-agency bulk purchasing system serving all state agencies that purchase pharmaceuticals, including the Departments of Health and Mental Health, state employees, retirees, teachers, and the prison system. The law creates the Interagency Council on Pharmaceuticals Bulk Purchasing, which the state estimates will save approximately $13 million in its first two years, beginning September 1.

For more information…

WWW The full text of the NGA's October 24 Issue Brief, "Pharmaceutical Purchasing Pools," is available in text, HTML, and PDF at the NGA Web site, **www.nga.org**. The PDF document is also available through PolicyBot, The Heartland Institute's free online research service. Point your Web browser to **www.heartland.org**, click on the PolicyBot icon, and search for document **#3264427**.

Skyrocketing Costs

In 1998, state Medicaid programs spent $11.7 billion on pharmaceutical purchases, an increase of $1.5 billion from 1997. Between 1990 and 1998, state spending on outpatient prescription drugs increased over 300 percent, from $4.8 billion to $14.8 billion.

"Pharmaceutical costs are one of the fastest growing state budgetary issues currently facing governors," noted John Thomasian, director of NGA's Center for Best Practices. "The development of both intrastate and interstate purchasing pools offers states the opportunity to wield significant market power and may result in the savings of hundreds of millions of dollars annually as additional states participate in such groups. West Virginia and the coalition states are at the forefront of developing new policies that hold down the rising costs of health care."

Founded in 1908, the NGA is the instrument through which the nation's governors collectively influence the development and implementation of national policy and apply creative leadership to state issues. Its members are the governors of the 50 states, three territories, and two commonwealths.

Christine LaPaille works in the Office of Public Affairs at the National Governors Association. She can be reached at 202/624-5334, email claPaille@mng.org.

Reduce Your Claims Processing "Paper Load"

AUTOMATE
Your HCFA 1500 and UB92
Claims Processing

ELA -- "The Intelligent Solution"

- Significantly Increase Operating Profit
- Slash Claims Processing Time
- Dramatically Improve Customer Service
- Immediately Reduce Data Entry Errors
- Customer Proven and Simple to Use
- Flexible, Scalable
- Fast ROI

ComCom
SYSTEMS, INC.
Data Capture and Document Imaging

Contact Us: Telephone: 727.725.3200 www.comcomsystems.net

cimrONE

The Proven Solution

Full Back Office Administration
From membership, eligibility and provider information to claims processing and payment – **cimr** is with you from start to finish.

Interactive Web Solution
Your members and providers can access your Web site for self-service.

HIPAA Relief
Your information is safeguarded throughout your **cimrONE** system.

Effortless Enhancements
cimrONE is one version – the most current version. Your system stays updated without being upgraded.

We are one of the largest claims processors in the world. What works for us will work for you.

cimr℠
Companion Information Management Resources
1-800-237-9922
PO BOX 100115 • COLUMBIA, SC 29202

LICENSED TO UNZ.ORG
ELECTRONIC REPRODUCTION PROHIBITED

Delta Air Lines employees listen to chairman and CEO Leo F. Mullin announce at a September 25 press conference that the Atlanta-based carrier will reduce up to 13,000 jobs and reduce flights by 15 percent. The reduction is a result of dramatically lower passenger demand for flights since the September 11 terrorist attack on the United States. Photo: Erik S. Lesser/Getty Images

What Congress Can Do to Provide Health Care Security for Displaced Workers

FSAs and tax credits can make a difference for tens of thousands of Americans . . . today

BY NINA OWCHARENKO

The September 11 terrorist attacks have created massive dislocations in certain sectors of an already-weakened American economy.

Within the major airlines, for example, 73,000 employees are expected to be laid off. American Airlines and United Airlines each announced they would cut 20,000 jobs; Continental expects to cut 12,000; US Airways estimates it will cut 11,000; and Northwest expects to cut 10,000. Airplane manufacturer Boeing may also lay off as many as 30,000 workers. The anticipated layoffs in related service industries and small businesses are just as staggering.

In addition to the fears regarding national security that many Americans face, tens of thousands of men and women must now cope with unexpected unemployment. The loss of income and benefits, particularly health care benefits, imposes additional pressure on these displaced workers.

In response to this situation, Senator Jean Carnahan (D-Missouri) recently introduced S. 1454, the Displaced Workers Assistance Act. The measure proposes a three-pronged strategy to target the needs of workers who have been laid off as a result of the September 11 tragedies.

Specifically, with regard to health care benefits, the bill provides for full federal reimbursement of COBRA (Consolidated Omnibus Budget Reconciliation Act of 1986) premiums and offers uninsured workers access to Medicaid coverage.

What Congress Can Do

The federal government can provide the economic victims of September 11 with the assistance they need to maintain solid health insurance coverage. But this need not entail locking those families into an inflexible government program. Medicaid is a welfare program that has provided substandard health care, and Congress should avoid enrolling working families in it.

> **"Medicaid is a welfare program that has provided substandard health care, and Congress should avoid enrolling working families in it."**

Instead, Congress should take steps to enable working families to get back on their feet and move back into private health insurance. Specifically, to ensure that displaced workers and victims' families will continue to have adequate health care coverage, Congress should:

* Allow rollovers of unspent health care flexible spending account (FSA) balances. Many employers, including US Airways and United Airlines, offer their employees FSAs, through which they can set aside a portion of their pre-tax earnings to pay for unreimbursed health care expenses during the plan year. However, at the end of the plan year or when employment is terminated (either voluntarily or involuntarily), any unused money in an employee's FSA must be forfeited to the employer.

At a minimum, Congress should allow workers whose employment is terminated involuntarily through recent layoffs and the families of deceased victims to keep any outstanding balance in their health care FSAs to help them pay for COBRA health care continuation coverage.

This can be accomplished by allowing the affected individuals and families to transfer their money to new FSA rollover accounts or to medical savings accounts (MSAs), as proposed by Representative Edward Royce (R-California) in H.R. 167, a broader FSA reform bill.

* Allow dislocated workers and affected families to continue making tax-free FSA contributions through the end of their current plan year. Not only do workers forfeit the unspent balances in their FSAs when they are terminated in the middle of a plan year, but they are also prevented from making any further planned contributions.

For example, an airline worker who had decided at the beginning of 2001 to set aside $100 a month, and was then laid off at the end of September as a result of the attack, would have contributed only $900 of the planned $1,200 contribution for the plan year. That denies the worker an additional $300 in pre-tax contribution to his or her FSA account.

Congress should allow these workers and families to fulfill their planned contribution, whether through an existing FSA or a new rollover FSA.

Tax Credits

In addition to easing up FSA restrictions, Congress can use refundable tax credits to help encourage recently displaced workers to participate in the private health insurance market.

* Provide refundable tax credits to displaced workers eligible for COBRA coverage. The federal government requires employers with 20 or more employees to offer continued group coverage to their employees and dependents after certain events, but it does not require the employer to contribute toward the premium. The cost of maintaining premiums without an employer's contribution can be unworkably high.

> **"Extend refundable tax credits to unemployed workers who are ineligible for COBRA or who are uninsured."**

A federal refundable tax credit would help displaced workers pay premiums for either COBRA or private replacement coverage. This assistance should be given at the time premiums are due rather than making people wait for the federal government to reimburse them. Such an approach would be especially helpful to low-wage workers with limited disposable income.

* Extend refundable tax credits to unemployed workers who are ineligible for COBRA or who are uninsured. There are many displaced workers who are not eligible for COBRA coverage because they worked for businesses with fewer than 20 employees, were not offered coverage by their employer, or chose not to participate in their employer's health care plan.

For these individuals and families, the federal government should offer a refundable tax credit, similar to the proposal described above with regard to COBRA, to help cover the cost of health care coverage. The credit could also be extended to previously uninsured workers as a way to encourage them to obtain coverage for themselves and their families.

Coordination with the Department of Labor and the U.S. Treasury could facilitate the administration of these tax credits. The Department of Labor could distribute the credits to the states, which in turn could direct them to their recipients through unemployment offices. Alternatively, the U.S. Treasury could assign the credit directly to an insurer, who would then reduce the premiums of participating individuals.

Both these options avoid saddling employers with unnecessary administrative burdens and ensure the tax credit directly benefits workers.

* Allow states to offer tax credits as well. Low-wage workers could be helped further if states were allowed to augment a federal tax

SECURITY continued on next page

LICENSED TO UNZ.ORG
ELECTRONIC REPRODUCTION PROHIBITED

MSAs Can Be a Windfall for All

Medical savings accounts encourage innovation and excellence in health care

BY GREG SCANDLEN

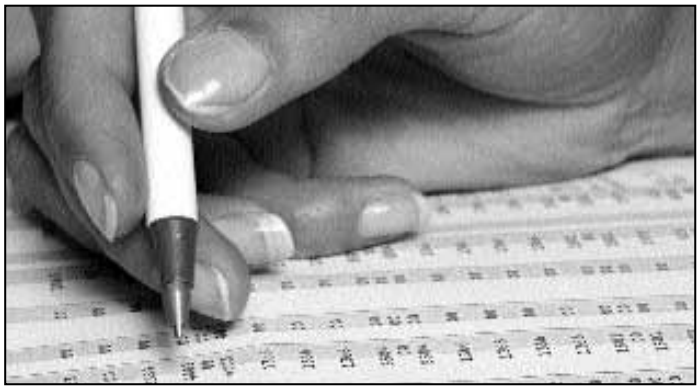
Outside of Washington policy circles, Medical Savings Accounts (MSAs) are no longer controversial. They stirred up a fuss when the concept was first introduced some 10 years ago. But at the time, most of the attention in Washington and across the country was on the promise of managed care to deliver optimal health care and control costs at the same time.

Ten years later, managed care has proven to be of limited value. It has generated a widespread "backlash" by patients, physicians, employers, and politicians. After 10 years of experience, patients believe managed care saves money only by depriving them of services they want and need. Physicians believe managed care prevents them from providing the care that is best for their patients. Employers are realizing managed care has not actually saved them any money; it just delayed cost increases for a few years. And politicians are sensitive to the discontent of their constituents.

Why MSAs Are Attractive

All of these parties have come to realize that managed care has not worked as a national policy in addressing the concerns of cost, access, quality, and patient satisfaction for the same reasons Medical Savings Accounts and other consumer-driven programs are attractive:

- MSAs work to restore the patient to a position of influence in the health care system, while managed care leaves the patient as a passive recipient of other people's decision-making.
- MSAs reduce the influence of third-party payers in the health care system, while managed care makes the third-party payer the predominant actor.
- MSAs help reduce costs by lessening the administrative burden on everybody, while managed care greatly increases the amount of health care dollars devoted to administration.
- MSAs help to restore the patient/physician relationship, while managed care weakens that relationship.
- MSAs encourage innovation and excellence in health care, while managed care encourages "cookbook" medicine.
- MSAs allow people to seek out alternative ways of maintaining and improving their health, while managed care either forbids or discourages alternative medicine.



Managing Editor's note: Greg Scandlen—senior fellow in health policy at the National Center for Policy Analysis and assistant editor of *Health Care News*—sits on top of the mountain when it comes to Medical Savings Accounts. We present here a small sample of the guru's larger work, certain to encourage and enlighten supporters and befuddle the minds that list to the left no matter which way the wind blows.

"MSAs increase quality by allowing patients to pay more to see a better doctor, while managed care tends to pay all participating doctors the same, regardless of their skill."

- MSAs encourage competition, while managed care encourages monopoly.
- MSAs facilitate portability for workers between jobs, while managed care locks workers into their current jobs.
- MSAs help assure continuity of care when patients change health insurers, while managed care disrupts continuity.
- MSAs enable people to seek the preventive care services best tailored to their own needs, while managed care covers only those services the bureaucracy prefers.
- MSAs increase quality by allowing patients to pay more to see a better doctor, while managed care tends to pay all participating doctors the same, regardless of their skill.
- MSAs allow people to build-up a source of funds to pay for future health care needs, including long-term care and insurance premiums while unemployed; managed care concentrates solely on the current year's expenses.

What's Appropriate for National Policy?

None of this is to say managed care programs are not attractive for some people, or that MSAs are the best solution at all times. The question, rather, is what should be the thrust of national policy?

Should it be reliance on empowered consumers making informed decisions through market mechanisms? Or should we rely instead on third-party bureaucrats allocating resources according to their preferences? The latter strategy has been tried and has failed. It is well past time to empower the patient.

Medical Savings Accounts are a broad term for the notion that much of health care can be paid directly by the consumer, and that government policy should be neutral as to whether such expenses are paid through an insurance mechanism or directly by the patient.

To the extent contributions to health insurance premiums are tax-advantaged, so should be contributions to an account dedicated to paying for health care expenses.

Once this concept is understood and adopted, consumers will be free to determine for themselves how best to allocate their resources between insurance coverage and direct payment. Some consumers may continue to prefer first-dollar insurance coverage, and they will put all their resources into premiums. Others may prefer a high-deductible health plan that covers only very expensive conditions, and pay for lower-cost services from an MSA.

Still others may prefer a mix, with insurance coverage that pays for "non-discretionary" spending combined with an account for "discretionary" services. Plans might develop that cover physician and hospital services with insurance, but use a cash account for dental, vision, pharmaceutical, and alternative services.

The specific benefit design can vary substantially, and policymakers cannot know ahead of time what the optimal mix will be in terms of efficiency and popularity. This is precisely what markets are superb at determining. Some designs will be tried and rejected in the market. Others will succeed and become the standard for future enhancements.

For more information…

WWW The full text version of "MSAs Can be a Windfall for All" is available at the Web site of the National Center for Policy Analysis at **www.ncpa.org/pub/bg/bg157/index.html.**

SECURITY continued from previous page

credit with their own credits by using Medicaid and the State Children's Health Insurance Program (SCHIP) funds.

The Department of Health and Human Services recently announced a Health Insurance Flexibility and Accountability Demonstration Initiative providing states with an opportunity to integrate Medicaid and SCHIP funding with private health insurance options. Offering this flexibility immediately would allow states to help displaced low-wage workers stay out of the ranks of the uninsured.

A good model for designing such tax credits is S. 590, the Relief, Equity, Access, and Coverage for Health (REACH) Act introduced by Senator Jim Jeffords (I-Vermont) with broad Senate support.

Military Aid

Similar tax credit assistance could also be extended to U.S. military reservists. As many as 35,000 reservists may be called up for duty.

Under the Uniformed Services Employment and Reemployment Act (USERRA) of 1994, reservists are able to continue participating in their employer-sponsored health plan for 18 months.

The employer is required to maintain their coverage for 30 days. After 30 days, the reservist may elect to stay with the employer-sponsored plan, but he or she becomes responsible for the full cost of the premium as described under COBRA; the employer is not required to contribute.

While TRICARE, the military health coverage plan, is offered to reservists after 30 days, many find its coverage inadequate. They, like displaced workers, should not fear losing their benefits.

Reservists who have FSA accounts with their employers should be able to contribute to and access those accounts while on duty. In addition, reservists should be eligible for a tax credit to help them maintain their employer-sponsored plans under COBRA or secure private replacement coverage.

Employer-Based System Flawed

The dislocation of workers and families affected by the September 11 terrorist attacks highlights the flaws that exist within the current employment-based system of health care coverage. Employees do not own or control their benefits, cannot carry them from job to job, and cannot maintain coverage during periods of unemployment.

America's health care system needs to be reformed to ensure that workers and their families have direct control over, and true portability in, their health insurance benefits.

Although it will take time to enact the necessary reforms to address all of the flaws in the current system, Congress can take some immediate actions to address the current health care crisis. Clearly, the solution does not lie in enrolling additional families in Medicaid, a health care welfare program with a dismal record of service and efficiency. American workers deserve better.

Congress can begin effective reform today by improving flexible spending accounts and providing refundable health care tax credits to displaced workers to help them maintain or purchase solid, private health care insurance.

Nina Owcharenko is health care policy analyst at The Heritage Foundation.

LICENSED TO UNZ.ORG
ELECTRONIC REPRODUCTION PROHIBITED

State Legislative Update

A year-end review of health care activity in the states

The year 2001 saw a wide range of health care proposals at the state level, including efforts to address long-term care, Medicaid access and budgets, mental health, prescription drug coverage, women's health, and SCHIP.

Unfortunately, many states passed new unfunded mandates, virtually guaranteeing further increases in insurance premiums—and increasing numbers of uninsured Americans. Efforts to tie low-income residents, senior citizens, and children to government-run medical care seem to be on the rise; Medicaid and SCHIP are becoming the default single-payer health care plan in many states.

Here are some highlights—and in some cases, low lights—from this year's state legislative sessions.

ALABAMA
Governor Don Siegelman (D) significantly increased funding for the expansion of community-based services for individuals served by the state's department of mental health and mental retardation. In addition, he signed legislation that expands Medicaid coverage to uninsured or under-insured women diagnosed with cervical or breast cancer.

ALASKA
Governor Tony Knowles (D) allocated revenue to the division of alcoholism and drug abuse to establish a juvenile alcohol awareness program and to increase community-based outpatient treatment for alcoholism.

ARIZONA
A pilot prescription program, signed into law by Governor Jane Dee Hull (R), establishes drug coverage for seniors with incomes between 100 and 200 percent of the federal poverty level. The program, aimed at seniors without access to Medicare managed care, requires a deductible, after which the state will pay 50 percent of prescribed medications.

Hull also promoted a bill allowing schools to get involved in the KidCare enrollment process. The new law also expands the KidCare benefit plan to the level of Medicaid benefits.

CALIFORNIA
Governor Gray Davis (D) included in his executive budget a provision extending health insurance to uninsured parents with incomes up to 200 percent of the federal poverty line through California's children's health insurance program.

Davis also announced a statewide initiative for prostate cancer treatment for low-income and uninsured men with the disease. The governor will devote $50 million in state general revenue and tobacco settlement funds to the initiative.

COLORADO
Recognizing the need for enhanced rural medical care, Governor Bill Owens (R) persuaded legislators to pass a bill expanding telemedicine services; giving municipalities the authority to contract with health care providers; and creating a task force to study problems unique to rural health care.

CONNECTICUT
Governor John G. Rowland (R) expanded ConnPACE to cover seniors and persons with disabilities. Eligibility levels were significantly increased from annual income limits of $15,001 to $20,000 for individuals and from $18,001 to $27,000 for couples.

DELAWARE
Governor Ruth Ann Minner (D) supported legislation calling for more expansive patient's rights protection. One feature of the bill calls for speedy arbitration when care is in dispute; another provides legal counsel for patients whose benefits have been wrongly denied.

FLORIDA
Governor Jeb Bush (R) signed legislation enabling the state to negotiate additional discounts on prescription drugs for Medicaid beneficiaries and to establish a preferred drug list with prior authorization. Savings could top $214 million a year, or 15 percent of the state Medicaid drug budget. In other legislation Bush signed, $53.7 million will be directed to community-based long-term care options.

HAWAII
Governor Benjamin Cayetano (D) signed into law a single insurance purchasing pool for state employees, in the hopes of strengthening the state's negotiating leverage with health insurance carriers.

IDAHO
Governor Dirk Kempthorne (R) unveiled a substance abuse treatment program to focus on care and prevention in the state's prison system and in community programs. The $5.7 million in funding comes from state revenues.

ILLINOIS
Governor George Ryan (R) signed a bill improving access to health insurance for state residents who lose employer-based insurance. Individuals will qualify under the HIPAA portion of the state's very successful Comprehensive Health Insurance Plan (CHIP). Ryan appropriated an additional $42 million in state revenue to further strengthen and expand the plan.

Ryan also signed two bills mandating the provision of health care services to women diagnosed with breast or cervical cancer. The first bill provides treatment for uninsured women who are screened by the CDC Breast and Cervical Cancer Early Detection Program. The second amends the insurance code to include coverage for breast reconstruction in connection with a mastectomy.

INDIANA
A bill expanding health insurance to uninsured parents by way of the Uninsured Parents Program Initiative was signed by Governor Frank O'Bannon (D). O'Bannon also supported legislation appropriating $29 million for SCHIP and $33.6 million to Hoosier Healthwise over the 2002-2003 biennium.

IOWA
Governor Tom Vilsack (D) signed the Senior Living Trust Fund appropriations bill, which provides community-based alternatives to nursing home care for elderly citizens and people with special needs. Pay raises for long-term care staff are also included in the bill.

KANSAS
Governor Bill Graves (R) signed off on legislation eliminating the mandatory waiting period for access to SCHIP.

LOUISIANA
Governor Mike Foster (R) approved legislation expanding health insurance coverage to children in families with incomes up to 200 percent of the federal poverty line. It is estimated 22,575 children will now be eligible for government-run health care.

MAINE
Independent Governor Angus King signed into law an act creating the Healthy Maine Prescription Program, which will provide low-cost medications to low-income and disabled seniors. King also signed a data collection bill authorizing retrieval and analysis of medical claims data. He rejected single-payer legislation passed by the state legislature.

MARYLAND
Governor Parris N. Glendening (D) allocated $6.5 million in new state funding for fiscal 2002 in order to expand the state's prescription drug program. Enabling legislation expands the children's program to families with incomes 300 percent of the federal poverty line, and to 250 percent of the federal poverty line for pregnant women. The law went into effect July 2001. An estimated 14,700 children can now enroll in the state SCHIP.

> **"Unfortunately, many states passed new unfunded mandates, virtually guaranteeing further increases in insurance premiums—and increasing numbers of uninsured Americans."**

MASSACHUSETTS
Acting Governor Jane Swift (R) awarded $7 million to community health centers around the state in an effort to support and strengthen efforts to improve access to health care.

MICHIGAN
EPIC, the state's Elder Prescription Insurance Coverage plan, was signed into law by Governor John Engler (R). The plan targets low-income seniors who do not otherwise have prescription drug coverage. The program includes coverage for insulin needles and syringes for diabetics.

Engler also awarded $10 million to rural communities as part of his Rural Health Initiatives Campaign.

MINNESOTA
Governor Jesse Ventura (MN Independence) advanced his state initiative to promote health care and preventative coverage for all Minnesota children. The Cover All Kids Coalition will conduct a public awareness campaign, identify practices facilitating public health program enrollment, and eliminate access barriers to preventative services.

MISSISSIPPI
Governor Ronnie Musgrove (D) approved the SCHIP reau-

LICENSED TO UNZ.ORG
ELECTRONIC REPRODUCTION PROHIBITED

thorization bill to continue the program for low- and moderate-income children.

MISSOURI
Governor Bob Holden (D) called legislators back into a second session in a successful effort to create a new prescription plan. The governor signed legislation scrapping a previous prescription plan, whose costs had reached $85 million a year on a $20 million projection. An independent actuary hired by the legislature projected a price tag of $99.6 million for the new program.

The governor also signed legislation directing $22.2 million of the tobacco settlement fund to implement a smoking prevention program for children and adults. He also signed a measure lowering the state's permitted blood alcohol level for drivers from 0.10 to 0.08.

MONTANA
Governor Judy Martz (R) secured funding for the development of the Montana Trauma System. It is described as a voluntary arrangement to provide an organized, preplanned response to trauma patients while helping maximize optimal patient outcomes in the face of limited health care resources.

Martz also secured additional funding for financially strapped nursing homes in 32 counties and secured approval for a Medicaid expansion to treat chemical dependency.

NEBRASKA
Biannual funding was increased $95 million by Governor Mike Johanns (R) for mental health and substance abuse services.

NEVADA
Governor Kenny C. Guinn (R) secured funding for the development of an electronic application process for the SCHIP program, Nevada Check Up, and Medicaid.

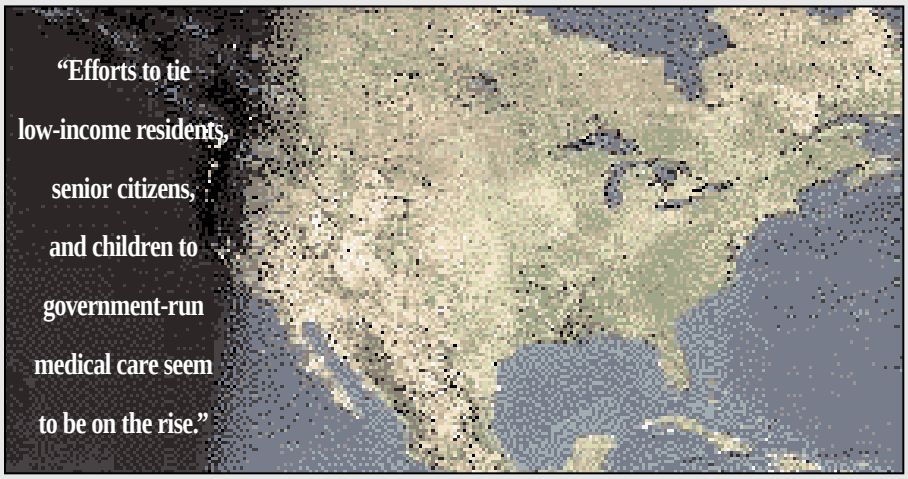
NEW HAMPSHIRE
Governor Jeanne Shaheen (D) was successful in getting $3.3 million in state funding for the continued expansion of the Healthy Kids SCHIP program, which enrolled 12,000 children in a little over two years.

NEW JERSEY
Acting Governor Donald T. DiFrancesco (R) signed the Breast and Cervical Treatment Act, thereby insuring treatment for uninsured women who meet a financial means test. The governor also authored and signed into law the Senior Gold Prescription Discount Act. The act provides the first state prescription drug benefit for moderate-income seniors and individuals with disabilities.

NEW YORK
Governor George E. Pataki (R) received federal approval for a Medicaid waiver allowing the state to extend benefits to over 600,000 low-income, uninsured residents, including 267,000 uninsured adults without children.

NORTH CAROLINA
Governor Mike Easley (D) announced the end of an enrollment freeze in the state's SCHIP program, NC Health Choice. This opens access for an additional 5,000 children.

NORTH DAKOTA
Governor John Hoeven (R) approved Medicaid changes to remove the asset test for families, expand coverage, simplify the application process, and improve coordination with SCHIP. Hoeven allocated $23 million to improving nursing home care and pay raises for long-term care staff.



OHIO
Governor Bob Taft (R) recruited 43 health care providers to work in medically under-served communities as part of an overall effort to reduce disparities in health care delivery by 2005.

OREGON
Legislation approving a medication assistance plan for low-income seniors was signed by Governor John Kitzhaber, MD (D). An estimated 110,000 state seniors meet eligibility requirements. Kitzhaber also negotiated a new drug formulary with the legislature. The state could save as much as $7 million over the next two years.

PENNSYLVANIA
Before leaving the governorship to take the new federal government position of Director of the Office of Homeland Security, Tom Ridge (R) signed legislation expanding the reach of existing drug plans for the elderly.

RHODE ISLAND
Two drug-related measures were signed into law by Governor Lincoln Almond (R). The first bill provides for the state to pay 100 percent of prescription drug costs for eligible individuals who spend at least $1,500 in co-payments through the state program during the state's fiscal year. The second bill added medicine for the treatment of osteoporosis to an existing list of covered drugs.

SOUTH DAKOTA
Governor Bill Janklow (R) expanded the state's All Women Count! breast and cervical cancer screening program to include treatment for low-income and uninsured women.

TENNESSEE
Governor Don Sundquist (R) promoted an agreement extending health coverage to uninsured adult citizens. The measure also preserves the general concept of TennCare, although changes to the way the program is run are underway.

TEXAS
Governor Rick Perry (R) signed a bill expanding the employer-based insurance market to enroll Medicaid and SCHIP beneficiaries. Under the law, the state will subsidize the health insurance of Medicaid and SCHIP enrollees who opt to enroll in employer-based plans. The state estimates it could save $8.5 million over five years.

The state SCHIP program was bolstered by a whopping $1 billion increase in funding. As a result, the state expects to enroll 500,000 children by the end of 2003.

Perry promoted an initiative dealing with underserved residents along the Texas-Mexico border, giving them improved access to previously unavailable specialized care through telemedicine and telehealth systems.

U.S. VIRGIN ISLANDS
Governor Charles Turnbull (D) appropriated tobacco settlement revenue for two new medical facilities providing critical cardiac and cancer care.

UTAH
Governor Michael O. Leavitt (R) signed six bills intended to prevent death and injury caused by intoxicated drivers. The new laws demand higher levels of accountability.

WASHINGTON
Legislation was signed by Governor Gary Locke (D) enabling low- to moderate-income citizens with disabilities to work without fear of losing Medicaid benefits. The law implements the federal Ticket to Work program, which permits people with disabilities to earn up to 450 percent of the federal poverty line—about $100,000 a year—and still remain on Medicaid assistance.

WEST VIRGINIA
Governor Bob Wise (D) signed a group pharmaceutical purchasing bill and initiated a multi-state drug purchasing pool. (See related story page 5.) Wise also enacted a Patient's Bill of Rights providing the right to sue an HMO for negligence resulting in patient harm. Wise also signed a measure to fund skilled nursing home facilities for U.S. armed forces veterans who are also state citizens.

WISCONSIN
Governor Scott McCallum (R) advanced his own legislative agenda and signed a drug assistance bill for the state's seniors. The new plan raises the income limit for eligibility to $20,616 for individuals and to $27,864 for couples—240 percent of the federal poverty line. McCallum expects to enroll 260,000 seniors.

WYOMING
Governor Jim Geringer (R) initiated long-term care reform by signing a bill allocating revenues for a study to evaluate the nursing home reimbursement formula; expand the long-term care home and community-based waiver programs; and increase the personal needs allowance from $30 to $50 a month.

The following organizations provided assistance in compiling this annual review: Stateline.org, the National Governors Association, and the National Association of Health Underwriters. For a more extensive review, go to www.nga/cda/files.001016HEALTHINT_PDF.pdf

LICENSED TO UNZ.ORG
ELECTRONIC REPRODUCTION PROHIBITED

Study: Affordable, Comprehensive Coverage Available

BY ROBERT MOFFIT

What do people actually buy if they have a chance to buy their own insurance coverage? Is there a real market out there that reflects consumer choice?

As it turns out, there is such a market . . . and groundbreaking research confirms not only its existence, but its strength.

The research is not based on surveys of health care benefit managers, assumptions or extrapolations based on employer-provided health insurance, or what employers or employees might think, but on real consumer behavior in the individual health insurance market.

At a June 21, 2001 press conference, the executives of eHealthInsurance outlined the findings of their study, "Analysis of National Sales Data of Individual and Family Health Insurance: Implications for Policymakers and the Effectiveness of Health Insurance Tax Credits." They were joined at the announcement by House Majority Leader Dick Armey (R-Texas), House Ways and Means Health Subcommittee Chairman Nancy Johnson (R-Connecticut), Representative William Lipinski (D-Illinois), and White House adviser Mark McClellan.

Policies Are Affordable

eHealthInsurance researchers examined 20,000 policies purchased in 42 states covering 95 percent of the U.S. population, divided about equally between men and women. The analysis included 7,000 different health policies offered by more than 70 insurers, including large Blue Cross/Blue Shield plans.

Among other things, the report finds health insurance policies are more affordable than commonly thought.

On average, monthly premiums for individual health insurance policies run between $100 and $125. According to the report, "These market data points from eHealthInsurance, together with average premium data from various health plans and government programs, all seem to refute the perception that average premiums are multiples of two to three times more." Insurance premiums in the individual market were found to be lower than those commonly found among small businesses in the small group market.

So why is the perception widespread that individual market premiums are much higher?

According to the report, "General perception may stem from specific high premium cases, rather than from statistically significant and geographically and demographically diverse data sets. Individuals paying high premiums may typically have pre-existing health conditions, be near Medicare age, or reside in one of the few states with high prices due to guaranteed issue regulation for the individual market."

Tax Credits Can Help

The study also concludes that tax credits make individual insurance policies even more affordable, particularly for low-income working people.

A generous tax credit proposal would be "meaningful," the study's authors note. Fully half of the individual and family policies analyzed in the study could be purchased for premium amounts within the limits of the proposed tax credits. Three-quarters of the policies have premiums within 75 to 100 percent of the tax credit amounts.

Coverage Is Comprehensive

According to the study, consumers purchasing coverage in the individual health insurance market buy "comprehensive" coverage, not just "basic" or "bare bones" coverage. Policies with a limited set of services and/or high deductibles—sometimes called "catastrophic" policies—were considered "basic" in the study. Policies were considered "comprehensive" if their coverage was equal to the current Medicare Part A and B benefit coverage with some level of Medicare supplemental coverage.

Eighty-eight percent of the insurance policies purchased by single individuals, and 84 percent of the plans purchased by families, were found to be in the "comprehensive" category.

In practice, this means the products consumers are already buying in the individual health insurance market offer coverage not just for hospitalization and physician services, but for a much wider range of benefits—including, almost invariably, prescription drugs.

Plans Have Low Deductibles

Consumers buying policies in the individual health insurance market are getting plans with modest deductibles.

According to the report, 80 percent of the consumers who purchased health maintenance organization (HMO) plans had no deductibles at all. Of the consumers who purchased preferred provider options (PPOs), 71 percent had annual deductibles of less than $1,000.

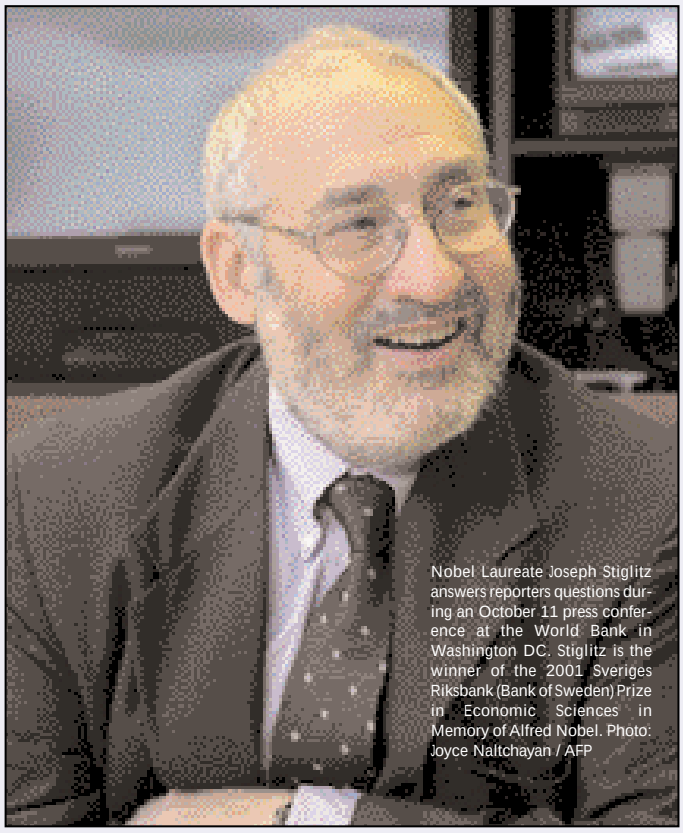
> **"Insurance premiums in the individual market were found to be lower than those commonly found among small businesses in the small group market."**

Consumers Prefer Less Interference

Consumers in the individual health insurance market show a strong preference for less insurance company management, rather than more. Seventy-five percent of consumers purchased PPO plans, while only 16 percent picked HMOs.

According to the report, "This would appear to contradict any assumption that policies in the individual market unduly restrict utilization of health services.

"Rather, it suggests that when confronted with the various tradeoffs and options, most consumers are willing to accept some, but not substantial,



Nobel Laureate Joseph Stiglitz answers reporters questions during an October 11 press conference at the World Bank in Washington DC. Stiglitz is the winner of the 2001 Sveriges Riksbank (Bank of Sweden) Prize in Economic Sciences in Memory of Alfred Nobel. Photo: Joyce Naltchayan / AFP

An Asymmetric Bias toward Government Regulation

BY VERONIQUE DERUGY AND TOM MILLER

Does the Nobel Prize committee know something health insurance markets don't?

In November, Joseph Stiglitz, George Akerlof, and Michael Spence shared this year's award for economics, primarily for their academic contributions to the economics of "asymmetric" information.

Theory Makes Bad Policy

Columbia University's Stiglitz is particularly noted for his emphasis on the possibility of market failure in competitive health insurance markets because of adverse selection and imperfect information. But his market skepticism has had its own adverse consequences, bolstering support for policies favoring more government regulation and less consumer choice.

In a seminal 1976 article, co-authored with Princeton economist Michael Rothschild, Stiglitz observed that if insurance buyers know more about their own health than do insurers, then buyers who know their risks are greater than average will purchase more insurance when it's priced based on average risk. Buyers who know their risks are less than average will purchase less insurance. This sequence of events is termed "adverse selection."

Over time, insurance premiums will increase as those with risks less than average self-insure more often and more extensively. In the worst-

> **"Consumer inertia, individual differences in aversion to risk, and the administrative complexities and costs involved in making risk adjustments . . . limit the applicability of adverse selection theory."**

case scenario, the overall health insurance market can break down completely.

Twenty-five years ago, Stiglitz wrote, "Do these theoretical speculations tell us anything about the real world? In the absence of empirical work it is hard to say."

LICENSED TO UNZ.ORG
ELECTRONIC REPRODUCTION PROHIBITED

restrictions in exchange for lower premiums."

Economists call this rational economic behavior. Consumers of health insurance, contrary to what critics of consumer choice sometimes assume, are not stupid.

Supports Tax Credits

The eHealthInsurance study has direct implications for consumer choice options being promoted by the Bush administration and conservatives and moderates in Congress.

For example, Armey and Lipinski have sponsored the Fair Care for the Uninsured Act (H.R. 1331), which would create a health insurance tax credit worth $1,000 per individual, $2,000 per couple, or up to $3,000 per family.

As Lipinski remarked, "Not only do eHealthInsurance's findings provide insight into the cost effectiveness of tax credits for the uninsured, but the data also proves that the proposed tax credit will cover plans that are good for the consumer."

According to White House health policy adviser McClellan, "The eHealthInsurance report, which is based on real world data on the affordability of private health insurance, is another piece of evidence showing that health insurance tax credits can significantly reduce the number of uninsured Americans. The report highlights the importance of implementing a workable tax credit, like that proposed by President Bush and many members of Congress."

Conclusion

The eHealthInsurance analysis is an unprecedented look into consumer behavior in the market for individual health insurance. For the first time, many assumptions about consumer behavior in the individual market have been refuted by evidence recorded in an entirely new and valuable database.

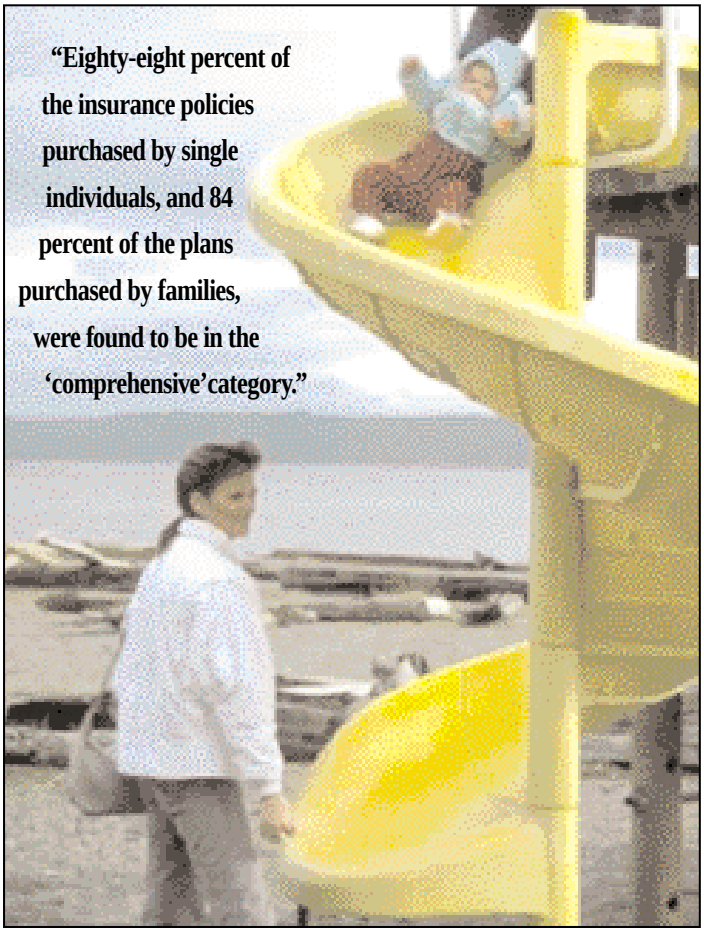
Individuals are willing to make rational economic trade-offs, buy plans with modest deductibles, and pay more for coverage more "comprehensive" than "basic."

Moreover, the affordability of such plans, clearly and convincingly documented by the eHealthInsurance report, means tax credits can have a significant positive impact on the nation's uninsured population. Tax credits have the potential to significantly reduce the cost of plans available in the individual market, making health insurance more widely available to families who need it.

Robert Moffit Ph.D. is director of domestic policy studies at The Heritage Foundation. This article is derived from a larger analysis published on July 13, 2001 as a Heritage Foundation Supplement, "What the Latest Market Research Reveals About the Viability of Tax Credits for Health Insurance."

For more information…

WWW The eHealthInsurance report, "Analysis of National Sales Data of Individual and Family Health Insurance: Implications for Policymakers and the Effectiveness of Health Insurance Tax Credits," is available on the Internet at **http://www.eHealthInsurance.com.**



"Eighty-eight percent of the insurance policies purchased by single individuals, and 84 percent of the plans purchased by families, were found to be in the 'comprehensive' category."

Unfortunately, health care policymakers have generally acted as if adverse selection was a dominant reality and not just a theoretical curiosity. Such thinking provided legitimacy for all sorts of regulatory interventions and compulsory health insurance schemes that favored equity over efficiency and risk-spreading over personal health maintenance incentives.

Government Failure, Not Market

By exaggerating the relative significance of adverse selection in health insurance markets, pro-regulatory forces could blame inefficient markets for leaving parts of the population uninsured.

Market-oriented reforms like medical savings accounts, defined contribution health plans, and Internet-based individual insurance options have collided with worries that they would increase adverse selection and make health insurance unaffordable for the high-risk people "left behind" in traditional employer group plans featuring comprehensive coverage.

To ward off such adverse selection, consumers are denied a level playing field for market-priced health care alternatives. They must maneuver past artificial barriers like mandated benefits, modified community rating, restrictions on risk classification, and regulatory cross-subsidies, as well as tax policies biased toward employer-sponsored group health insurance.

Ironically, public policy barriers to competitive choices in health care represent government failure—built not only on imperfect information, but on deeply flawed assumptions.

Adverse Selection Doesn't Apply

There's little evidence that individuals and families can identify and anticipate most of their future medical expenses in ways potential insurers cannot.

In a study forthcoming from the Cato Institute, James Cardon and Igal Hendel find little empirical evidence of information asymmetries, market failure, and adverse selection in health insurance markets. They note that differences in health expenditures between the insured and uninsured are mostly due to observable differences in demographics (age, gender) and price sensitivities (higher-income workers capture more tax subsidies for insurance coverage), rather than unobservable factors related to health status.

Private insurers aren't helpless or clueless when it comes to adverse selection. They may use such tools as setting limits on plan switching, varying premiums according to the amount of insurance purchased, underwriting and rating based on risk categories, creating more homogeneous risk pools, or relying on the law of large numbers to diversify risks in large employer pools.

Consumer inertia, individual differences in aversion to risk, and the administrative complexities and costs involved in making risk adjustments within group health plans all further limit the applicability of adverse selection theory to the actual health insurance world.

Government Intervention

Many of the difficulties we observe in health insurance markets are due to government intervention rather than adverse selection or other market failures.

"Many of the difficulties we observe in health insurance markets are due to government intervention."

If insurers are not allowed to charge different premiums to different risks in competitive markets, they may resort to excluding or discouraging coverage of high risks. Cream-skimming (selecting only the best risks) becomes the insurers' mirror image of adverse selection by insurance customers.

Political interventions in health insurance markets don't alleviate underlying differences in risk across customers or eliminate insurers' knowledge of such differences. They only force insurance companies to cope in inefficient ways and create new problems.

Health status information is most likely to be asymmetric when it is scarce and costly. While government mechanisms prefer to ignore, hide, or shift those information costs, markets create proper incentives to discover efficient ways to signal relevant private information and put it to use.

Need for Reform

Market mechanisms can't eliminate every unfortunate human experience in health care access, affordability, and quality. Private charity and a backup safety net of transparent, direct subsidies have necessary roles to play.

Beyond a certain point, any reductions in adverse selection will cost more than they are worth. But we do need to open more breathing room for market innovations to fill the real gaps that exist in insurance coverage. Effective reforms include bolstering incentives for new forms of voluntary risk pooling and long-term insurance contracts, deregulating insurance choices, and providing tax equity for all insurance purchasers.

The growing availability of online health information and insurance products further strengthens the case for empowered consumers. Unlike centralized government "solutions," markets don't promise perfect outcomes, just better ones.

Veronique deRugy is a health policy analyst and Tom Miller is director of health policy studies at the Cato Institute. Miller is also a contributing editor for Health Care News.

LICENSED TO UNZ.ORG
ELECTRONIC REPRODUCTION PROHIBITED

Prescription Drugs Rationed by Lottery

How do the British address prescription drug coverage—currently among the most contentious of health care issues in the U.S.? Not in any way we'd consider to be a model.

To restrict supply, the British use a form of price controls, setting for each pharmaceutical company a target profit for all its sales to the NHS. Pharmaceutical firms aren't permitted to profit more than the government thinks they ought to—a sure way to arrest research and development.

In addition, the British employ measures to reduce demand. The most recent of these is the National Institute for Clinical Excellence (NICE). Established last year, the program exists to evaluate medical technologies, especially new and expensive ones. Although the name implies independence, it is yet another bureaucracy within the NHS.

Proponents say NICE will end the "postcode lottery," a method used for rationing prescription drugs. To date, it has failed to do so.

The simplest way to describe this nonsensical approach to rationing pharmaceutical drugs is to call it a health care lottery based on a consumer's zip code. The prize is your eligibility to receive free medication. But the lottery prize is not permanent. The "lucky" postcode can change and seems to be based on political expediency rather than medical necessity.

> **"The 'lucky' postcode can change and seems to be based on political expediency rather than medical necessity."**

Imagine living in one postcode and getting life-saving medications free from the NHS. Then imagine being notified the postcode has changed. You no longer qualify for the medication, because the free postcode moved across the street or across town, and you didn't.

The NHS failed to respond to my repeated requests for information about how the qualifying postcode is selected.

Looking for an outstanding speaker?

Who is Dr. Merrill Matthews?

Merrill Matthews Jr., Ph.D., is a Heartland Senior Fellow specializing in health care policy and a visiting scholar with the Institute for Policy Innovation. Dr. Matthews is past president of the Health Economics Roundtable for the National Association for Business Economics, the largest trade association of business economists, and health policy advisor to the American Legislative Exchange Council, a bipartisan association of state legislators.

"Don't miss an opportunity to hear Merrill Matthews speak. He's knowledgeable, thoughtful, articulate,usually right, and always entertaining."

STEPHEN MOSES CENTER FOR LONG-TERM CARE FINANCING

Engagements are scheduled on a "first come, first served" basis. Call public affairs director Greg Lackner at 312/377-4000 today to schedule Dr. Merrill Matthews to keynote your next event!

ENGLAND continued from page 1

anywhere near up to the task.

Ninety percent of Britons must access medical care through the NHS bureaucracy; just 10 percent of the population subscribes to private health insurance and medical care. The NHS encompasses all of the English mainland, Northern Ireland, Scotland, and Wales.

A Little History

Founded in 1948, the NHS was based on Germany's centralized health care system, and it is not unlike China's social insurance plan. In recent years, those programs have weakened … and Britain's is not far behind.

The German "sickness insurance" approach has evolved into a two-tiered system. About 75 percent of German residents are covered by compulsory government health insurance: you must have it, and your employer must provide it. A rapidly growing 25 percent are now covered by private health insurance—which is also compulsory.

In April 2001, the Chinese government declared its socialized health care system dead. Hospitals are now encouraged to compete, and consumers are expected to pay. The first $240 of medical expenses are paid from a social insurance fund with individuals paying half the cost of medical care out-of-pocket. A mutual fund, similar to state-run high-risk health insurance pools (HIPs) in the U.S., exists for those with exceptionally high medical expenses.

Germany and China are part of an international trend toward less government interference and greater individual responsibility in health care. While there are dramatic demographic differences between Germany and China, both have embraced the competition and consumer choice that are keystones of free-market health insurance and health care delivery.

NHS now distinguishes itself internationally by recognizing neither competition nor consumer choice. This was made abundantly clear to me this summer, while I spent time in London on a fact-finding trip.

In the final days of this year's re-election campaign, the title of a June 2 editorial in the *London Express* declared its unwavering support for NHS and the status quo: "It's the Principle That Matters, Not Consumer Rights."

Examining the Bureaucracy

In a sprawling arrangement reminiscent of the failed Clinton national health care scheme, the NHS is a "top-down" approach to the delivery of health care.

The Department of Health has offices in Leeds and London as well as eight regional offices. Its primary function is to develop standards of patient care and enforce rules governing how care is delivered, to ensure the standards are met.

In England and Wales, local NHS Trusts develop proposals requesting funding for the health services they deem needed by their service areas. Those proposals are submitted to the central Health Authorities, who evaluate the requests and fund them. In Scotland, various Health Boards carry out the evaluating/funding function, and in Northern Ireland it is the responsibility of the Health and Social Services Boards.

A board of executive and non-executive directors rules over each Health Authority. The chairperson of each authority appoints directors. Each authority is monitored by the regional office which, in turn, is monitored by a regional NHS executive who is monitored by the government.

> **"We are running flat out already; there is no spare capacity. Even if we have just an averagely bad winter, we will be in for trouble. There will be a lot of patients having their operations cancelled."**
>
> **DR. PETER HAWKER, CHAIRMAN CENTRAL CONSULTANT'S COMMITTEE BRITISH MEDICAL ASSOCIATION**

The NHS Direct office opened in March 1998 and was designed to offer patients 24-hour advice on health care. In practice, NHS Direct acts as a "gate-keeper." NHS Direct nurses offer advice and reassurance on how patients can take care of themselves at home. For more serious conditions, the nurses advise on what actions to take. If appropriate, the nurse will call for an ambulance.

NHS Trusts, or hospital trusts, are found in most large towns and cities and claim to offer a wide range of health care services through centers and clinics. The trusts also make house calls to patients living in rural communities. Except in the case of emergencies, a referral for hospi-

ENGLAND continued on next page

LICENSED TO UNZ.ORG
ELECTRONIC REPRODUCTION PROHIBITED

ENGLAND continued from previous page

tal admittance can be made only by a general practitioner (GP). Appointments and treatment by the GP are free.

Together, the NHS Trusts employ most of the health care system's workforce, including doctors, nurses, dentists, pharmacists, and midwives.

Support professionals, including physiotherapists, radiologists, podiatrists, speech and occupational therapists, psychologists, and administrative staff—from receptionists to maintenance workers—are also employed by the NHS.

"According to a recent survey conducted by the British Medical Association, almost half of the GPs interviewed said they plan to retire before the age of 60."

Signs of Dissatisfaction

As the British media regularly reports, beneficiaries of the NHS all too frequently don't get timely care; are subjected to queuing for 12 months or more; get better on their own; are sent to other countries for care; are shifted to the private sector for care; or die while on the waiting list to see a doctor or gain access to a hospital.

But of the many indicators pointing to a dysfunctional NHS, the dissatisfaction of medical professionals rises to the surface as possibly the single most serious issue capable of undermining all confidence in the British health care arrangement.

Zosia Kmietowicz wrote in the October 20, 2001 issue of the *British Medical Journal*, "one in four general practitioners (GPs) in Britain's National Health Service is seriously considering leaving general practice."

According to a recent survey conducted by the British Medical Association (BMA), almost half of the GPs interviewed said they plan to retire before the age of 60. The BMA said the findings show the scale of the challenge facing the government as it seeks to recruit and retain doctors and bring down long waiting lists for medical treatment.

Two-thirds of the 42,360 GPs surveyed complained morale in the profession is low or very low. Nearly two-thirds say it is worse now than it was five years ago.

The study exposes the current working conditions under the NHS:

- Most GPs have between 1,500 and 2,500 patients, and more than one-quarter manage between 2,000 and 3,000 patients.
- Ninety-three percent say they want to treat a smaller number of patients.
- Ninety-three percent say they want longer consultations with patients.
- One in five complain work-related stress is excessive and unmanageable.
- More than half say the extent to which work impinges on their quality of life is unacceptable.
- More than 80 percent feel the government's plans for improving the NHS are unrealistic and cannot be achieved in the given 10-year time frame.

In May 2001, a ballot of all GPs indicated 86 percent of those who voted would be prepared to consider resigning from their current contract if a better contract and negotiating rights cannot be secured by April 2002.

Waiting for the Next Crisis

According to Anthony Brown, health editor of *The Observer*, "Britain's hospitals are facing a winter crisis similar to that of two years ago, when the NHS came close to collapse."

In the winter of 1999-2000, the NHS almost ground to a halt because of an influenza epidemic. Almost all non-emergency operations were cancelled, and at one point the country was left with just two intensive-care beds, with patients shuttled hundreds of miles in search of somewhere to stay.

The crisis shook the public's faith in the NHS and forced Prime Minister Tony Blair to launch a national plan to save it. A similar crisis was avoided last year because the flu season was unusually mild.

Doctors are convinced the NHS is heading for a similar crisis this year. Jonathan Fielden, clinical director of emergency services at Royal Berkshire & Battle Hospital, said, "This year we are more concerned—hospitals are already in perpetual crisis, even during the summer, and there are reports the Sydney flu might hit us. I think it likely the crisis will be as bad as two years ago."

According to reports I read while in London, intensive-care beds in the country should be running at less than 85 percent occupancy . . . but most hospitals I contacted were running at over 90 percent occupancy. In November, an Audit Commission report showed emergency room capabilities were deteriorating rapidly.

Dr. Peter Hawker, chairman of the British Medical Association's Central Consultant's Committee, warned, "We are running flat out already; there is no spare capacity. Even if we have just an averagely bad winter, we will be in for trouble. There will be a lot of patients having their operations cancelled."

For more information…

WWW The text of Zosia Kmietowicz's article in the October 20, 2001 issue of the *British Medical Journal*, "Quarter of GPs want to quit, BMA survey shows," is available on the Internet at **http://bmj.com/cgi/content/full/323/7318/887.**

Anthony Browne, health reporter for *The Observer*, can be reached by email at anthony.browne@observer.co.uk.

Paying for the Bureaucracy

The British approach is to say all health care should be equal, so there is no difference between the standard of care enjoyed by the rich and the poor. The NHS emphasizes equality first, consumer rights last.

This approach, repeatedly defended by successive English governments, is hardly free. The burden on the public—measured by heavy income taxes, insurance premiums, and stress—is significant.

Steve Whitlam, Knowledge Systems Manager for the London Regional Office of the NHS, explained to me there is no such thing as NHS Insurance. "United Kingdom employees and employers pay National Health insurance contributions which help fund the NHS as well as providing other social welfare benefits." This socialized entitlement system includes Incapacity Benefits (like long-term care and disability insurance,) Jobseeker's Allowance, Maternity Allowance, Retirement Pension, Widowed Mothers Allowance, Widows Payment, and Widows Pension.

Whitlam further explained 13 percent of NHS funding comes from National Insurance contributions; the remainder comes from general taxation and some patient charges for eye tests and dental care.

National Insurance contributions are 10 percent of the employee's gross earnings, starting at £87 per week ($124), to an upper weekly limit of £575 ($820). The employer contributes 11.9 percent of the employee's gross.

An income tax is also levied on earnings over a personal allowance of £4,535 per year ($6,467). Income over this amount is taxed at 10 percent for the first £1,800 ($2,681). The next £29,400 ($41,927) is taxed at 22 percent. For those earning more than £29,400 over the personal allowance, the tax is 40 percent.

Health Care Utopia?

In its publications and on its Web site (www.nhs.uk), NHS touts its coverage as being "equal in a manner of uniformity across the country and a uniformity between rich and poor, comprehensive, of the highest standard, and free at the time of use."

As I have come to understand the NHS, these are grand overstatements of the program's success, part of a politically incorrect problem: If you criticize the NHS, you will come under attack for being against "the best." In England, being against "the best" is like making a slur against the Queen.

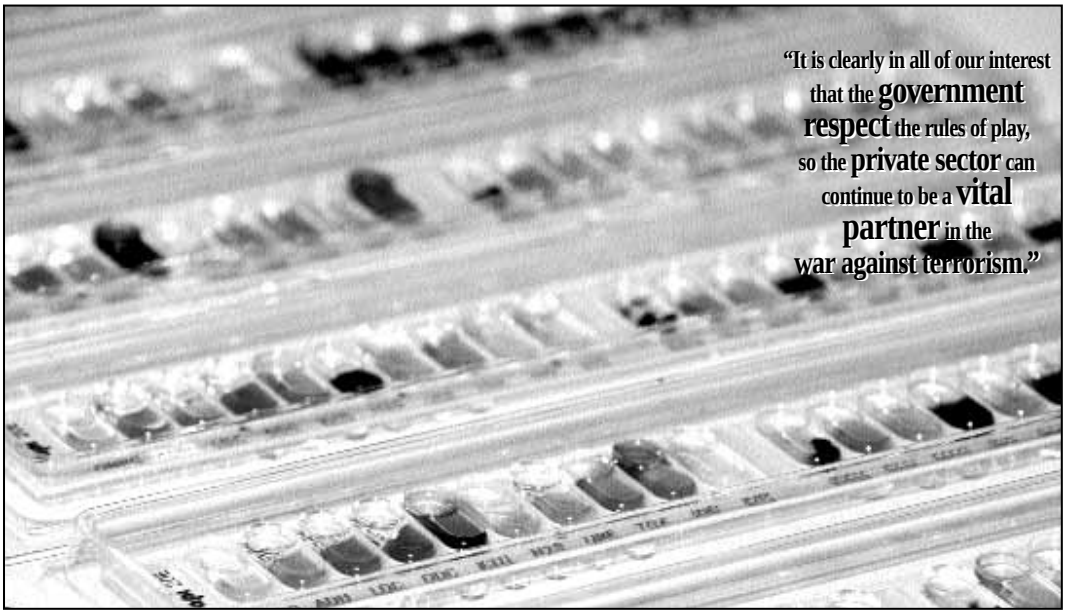
I'll risk being improper: The facts do not support "the best" claim. The NHS achieves only one of its stated goals, being largely free of direct payments, co-pays, and deductibles. It is this single-mindedness to avoid charges that makes it impossible for the system to achieve its remaining goals.

At the heart of single-payer health care in general, and the NHS in particular, is a belief that health care is a right, and government has the responsibility to provide it. This belief, more than any other factor, makes reforming British health care a daunting task vulnerable to political posturing and social unrest.

According to Eammon Butler, director of the highly regarded Adam Smith Institute, "the Prime Minister wants to see more NHS cases going to private hospitals, but private providers will be very wary of investing in that, if they think that ministers might subsequently change their minds and leave private hospitals bankrupt, ready for picking by the state. The only solution is to go beyond this: to allow the public to choose service providers for themselves, not to have politicians directing public budgets on their behalf."

Next month: British policy experts propose greater freedom of choice in health care.

LICENSED TO UNZ.ORG
ELECTRONIC REPRODUCTION PROHIBITED


"It is clearly in all of our interest that the government respect the rules of play, so the private sector can continue to be a vital partner in the war against terrorism."

Private Sector Responds to Bioterrorism

BY GRACE-MARIE TURNER

As the anthrax scare has mushroomed, modern technology's solutions have emerged like a quick strike force.

Medical treatment was instantly available with the antibiotic, Cipro. The manufacturer, Bayer Corporation, is ramping up production to produce 200 million doses in three months.

And now, new technologies are being offered to the U.S. Postal Service to sanitize and kill anthrax or other bacteria before the mail is sorted, delivered, or opened.

Pharmaceutical Companies Respond

It is worth noting that all of these solutions to a public health threat have come from the private sector.

Cipro was introduced by Bayer in 1987. It is approved to treat 14 different ailments, including respiratory and urinary tract infections. Just last year, the company completed the expensive and complex process necessary to add anthrax to that list.

> **"It is worth noting that all of these solutions to a public health threat have come from the private sector."**

Bayer announced it will work around the clock to meet demand for the product.

It is also clear that other medicines are effective against the anthrax threat. The Food and Drug Administration informed physicians on October 18 they could use another antibiotic, doxycycline, to treat anthrax "in all its forms."

Pfizer introduced doxycycline under the brand name Vibramycin in 1967. While the company is ready to produce as much of the compound as needed, generic manufacturers also can manufacture it, since Pfizer's patent has expired.

With additional drugs and huge manufacturing capability available, shortages of anthrax-targeting drugs are highly unlikely. "This is a perfect show of our U.S. market working well—a dynamic generic sector and a dynamic research-based sector working hand in hand," a Pfizer executive observed.

Preventing the Threat

Not merely prepared to *respond* to the anthrax threat once Americans have been exposed, the private sector may be able to *prevent* exposure in the first place, through irradiation technology. A large and robust industry already uses irradiation to sanitize medical supplies and to treat fruits, vegetables, and meats to increase their shelf life and kill harmful bacteria.

Irradiation equipment is capable of zapping the products in bulk, often on assembly lines, and there is strong evidence irradiation also could kill powdered bacterial spores of anthrax in unopened mail.

According to Jeffrey Barach of the National Food Processors Association, "Irradiation doesn't do anything to [harm] the mail. It certainly doesn't make the produce radioactive or leave any residue."

Out of the Way

It is vital that our federal government, in this time of crisis, not undermine the free-market dynamics that make these resources available.

That almost happened in Canada in late October. In a panic, Canadian Deputy Prime Minister Herb Gray decided to stockpile Cipro and asked a Canadian generic drug manufacturer, Apotex Inc., to produce the pills, clearly violating Bayer's patent on the drug.

Canadian officials said they ordered the generics under a government emergency clause because they feared Bayer couldn't meet the order. After a firestorm of opposition, the government backed down.

Under an agreement with the Canadian government, Bayer will supply one million Cipro tablets within 48 hours on demand. In return, Canadian health authorities will respect the company's existing patent rights and will acquire the antibiotic exclusively from Bayer during the period of patent protection.

"The moment that Bayer said we have bins of pills in the warehouse and you can have them tomorrow, there was nothing else [for the government] to talk about," one Canadian official said. "There is no way that the Patent Act cannot be respected."

New York Senator Charles Schumer also threatened to violate Bayer's intellectual property rights when he called for U.S. government action to allow generic production of Cipro. Fortunately, our government is doing the right thing at the moment.

Health and Human Services Secretary Tommy Thompson says he has no "current plans" to override Bayer's patent protection. Let's just hope he drops the "current" from future statements. Violating a firm's patent would be a devastating blow to the research-based pharmaceutical industry … and to anyone relying on their products.

Discouraging Future R&D

Pharmaceutical firms invest, on average, more than $500 million in research to bring a single new drug to market. Violating pharmaceutical patent rights today would discourage the development of products that will be needed to address new health threats in the future.

If the government were to steal their intellectual property, what possible incentive would pharmaceutical companies have to continue to make such an investment for the future so they can be ready to respond to the next threat?

It is clearly in all of our interest that the government respect the rules of play, so the private sector can continue to be a vital partner in the war against terrorism.

Grace-Marie Turner is president of the Galen Institute, a health policy research organization based in Alexandria, Virginia. www.galen.org

Anthrax 101

BY DR. MICHAEL A. GLUECK AND DR. ROBERT J. CIHAK

Nature abhors a vacuum. That's why the media must fill every second of air time and every column inch of page space.

But where the talking heads and instant experts are concerned, nature apparently loves the vacuous and the vaguely alarmist, the alarmingly vague, and those genuine experts struggling to explain it all in 30 seconds or 750 words or less.

Putting the Threat in Perspective

By now, no doubt, you've been utterly overanthraxed by the media. (If only words could inoculate, we'd all be immune.) But chances are that you and yours, and everybody else's, are still alive and well. Let's put these bad bugs into perspective and try to separate fact from fairy tale.

First of all, don't paralyze yourself with worry. Maintain perspective. WorldNet Daily's Paul Sperry recently offered an excellent perspective. As he noted, even the 6,000 people killed directly by the suicidal airplane hijackers on September 11 aren't as many as the children who died that same day—and die *every* day around the world—from malaria preventable by DDT.

> **"In case of a major biological or chemical attack, you cut your risk in half if you simply stay inside your house."**

Please also remember that we Americans number almost 300,000,000. Only a minuscule fraction of us were even exposed to anthrax during the events of the past three months. Even if terrorists attack America again, you're still much more likely, statistically speaking, to suffer a serious heart attack or traffic accident than to fall victim to a terrorist attack.

Driving while tired or distracted, not to mention yakking on your cell phone, is far more dangerous than what we've seen of germ warfare so far. There's no way to know for sure, of course, but we suspect more people will die from uncommon fatal reactions to Cipro and vaccinations than from germs released by terrorists.

Why Anthrax?

The germ *du jour* is anthrax because, ounce for ounce, it has the potential to be the most lethal of all germs—but if, and only if, the germs are prepared in exactly the right way.

The recipe has to be just right, not too hot and not too cold. The germs must be spread

ANTHRAX continued on next page

LICENSED TO UNZ.ORG
ELECTRONIC REPRODUCTION PROHIBITED

ONLINE continued from page 1

it's hardly a miracle of one-stop shopping.

While consumers can buy car insurance online within minutes, small businesses confront an online application process that requires the same amount of work as visiting a broker in person. When buying a health plan online, the customer may have to interact with a broker before purchasing the final product.

Obtaining a price quote, however, is fairly straightforward. The quote is based on basic company and employee information.

First, the prospective buyer must fill out his or her name and the company name, the company's address, and its line of business—either with a Standard Industry Classification (SIC) code, or with a descriptive keyword. The quote process also requires the user to indicate how many employees will be covered.

Next is an employee census: name, gender, and age of each employee. Some sites ask for specific birth dates, while others ask just for ages. For each employee, the user must indicate whether a spouse or children will be covered under the plan.

The next step allows the user to outline plan requirements: Maternity coverage? Dental insurance? Deductibles for hospital stays? These add-ons increase the cost. Applicants must also know how much of the premium will be paid by the employer and how much by the employees.

That's all it takes to get a preliminary rate quote. The user will then be asked how to compare the plans that meet the criteria specified: by price, deductible, or plan features. What happens next depends on the site, and whether it acts as a broker or refers the user to a local broker.

Online Brokers and Referrals

Sites such as eHealthInsurance and Quotesmith provide instant quotes on various health plans. The user can move from the quote to the application process by sending an e-mailed request to the site. From there, the user goes through an application process similar to what takes place in the office of an offline agent, supplying health histories of employees and any covered family members, and providing wage and tax forms in order to receive a final premium rate.

Other sites, including BenefitMall and Firstdoor.com, will refer users to a broker. BenefitMall refers to a local broker, while Firstdoor allows brokers to bid for business in its online "marketplace."

"We're agnostic when it comes to whether a small business buys insurance from a carrier directly, from our marketplace, or through traditional channels," says Dukes of Firstdoor.

"Our goal is to help businesses make a better buying decision. They can take our information to their broker and reaffirm what we've told them."

Too Soon to Tell?

The California HealthCare Foundation's (CHCF) recent report, *Health Insurance: Purchasing and Privacy Online for Individuals and Small Groups*, offers a snapshot of site features and performance for three online health insurance sites: eHealthInsurance, HealthAxis, and Quotesmith.

> **"Site features run the gamut, from bare-bones quoting services offering no insurance advice, to sites that bill themselves as 'benefit portals'."**

The report warns it may be too early to draw conclusions about such a young marketplace, and raises issues of concern to consumers using the sites. CHCF found buying health insurance online means being faced with a limited range of product choices. "Some sites offer a full range of products (e.g., HMO, PPO) for each health plan they offer; others are more restrictive in the product choices they present," the study notes.

And so far, there's no apples-to-apples way to compare quoted health plans, or even to make clear preferences for deductibles, co-payments, and other important plan features.

Before a user starts the application process, he or she should be aware of what options can legally be offered in that state. Pickings can be slim, depending on location. For instance, consumers in California, the largest insurance market in the country, have many more health plan options than do Alaska residents, who might have only one or two choices.

Privacy Online

The CHCF report's most intriguing question is that of consumer privacy in online health plan applications. To obtain a quote, a user must enter health data for all the firm's employees. That's important data . . . and it represents a potential gold mine for the site.

Fortunately, the CHCF study found that although privacy policies could be better explained at the sites in question, there is no evidence that private information is anything but confidential.

Where does online information go? "That can be made more transparent, though it's not clear that any more privacy risk exists online than through traditional channels," says Marian Mulkey, program director at CHCF.

Overall, online health insurance sites can be a benefit to independent-minded small businesses and individuals, Mulkey says. "For some people, it's a personal preference. Some people prefer to shop for insurance on their own time frame. Online, you can shop on your own," Mulkey says.

Heather Williams writes for insure.com, the Consumer Insurance Guide.

ANTHRAX continued from previous page

in just the right size, not too big and not too small. They must be delivered with the wind just right, and without any rain. To cook up a batch requires laboratories and equipment costing hundreds of millions of dollars.

> **"Nature abhors a vacuum. That's why the media must fill every second of air time and every column inch of page space."**

Only a few countries have them. The United States and Russia, for sure. Iran? Iraq? A cave somewhere in Talibania? Perhaps. This stuff is far from readily available. As Conrad Chester, a former Oak Ridge National Laboratory scientist and expert on biological weapons, titled his talk at a Doctors for Disaster Preparedness meeting: "Terrorists Have Problems, Too."

Now the Good News

With nearly all germs, as with other agents, the dosage determines the poison. Almost anything is poisonous in large enough quantities. Many people—wool sorters for example—are routinely exposed to small numbers of anthrax germs and don't get sick.

You can't catch anthrax from someone with an anthrax lung infection. Other anthrax infections, such as in the skin, are easily cured. As with all infections, you should avoid contact with an infected person. You shouldn't self-medicate.

In case of a major biological or chemical attack, you cut your risk in half if you simply stay inside your house. You can cut the risk by another factor of 10 by making a "safe room." Select a room with essentials (bath, water, food, TV, radio, telephone, games for the kids). Duct tape the windows and have towels available to moisten and jam around the doors.

"Don't wait for the government to protect you," urges Dr. Jane Orient, president of Doctors for Disaster Preparedness (DDP). "Your family's safety is your responsibility." DDP has additional information about many of these topics on its Web site (http://www.oism.org/ddp/), including detailed sealed-room information and the federal government's publication, *Treatment of Biological Warfare Agent Casualties*.

If a situation does arise where you suspect exposure, call your physician or the nearest emergency personnel. Do not take two aspirins or wait until morning . . . but do take a deep breath, far away from the powder.

Perhaps we all need one. And while we're breathing, we might consider anew just how precious and fragile civilization is, and how great is the evil of those who seek to destroy it.

Dr. Michael A. Glueck has written extensively on medical and legal reform issues. Dr. Robert J. Chiak is president of the Association of American Physicians and Surgeons (AAPS).

The science of transplantation is best measured by the impact it has on everyday life. When a transplant is needed, your care rests entirely in the hands of others. Patients and their payors take comfort in knowing they have access to the extensive clinical expertise found within our transplant network. Put your transplant benefit management needs into the hands of the recognized experts. United Resource Networks. **1-877-572-3042**

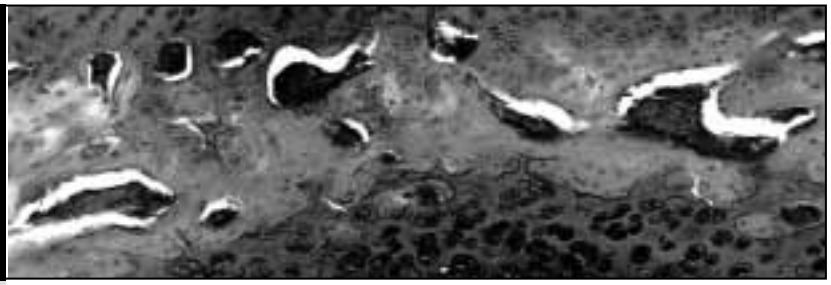
United Resource Networks

© 2001 United Resource Networks

LICENSED TO UNZ.ORG
ELECTRONIC REPRODUCTION PROHIBITED

THE GALEN REPORT

A monthly review of health policy matters



I have been criss-crossing the country and, as a result, I have no idea what—if anything—is happening in Washington on health policy. But I can report on some of the conferences and events I have been participating in.

Los Angeles

In Los Angeles, I spoke for an hour to 100 judges attending Chapman University's symposium on "Health Care: Economics, Law, and Public Policy." These judges were tough customers who cross-examined me throughout the presentation, but they seemed genuinely interested in and intrigued by ideas for free-market options to help the uninsured gain access to private health coverage.

One Circuit Court judge from Chicago was skeptical about where people would purchase insurance with a refundable tax credit and how people would negotiate the complex world of insurance coverage.

I explained the market would respond with new group plans qualified under government rules and organized by existing health plans, churches, associations, trade unions, and companies like John Deere that would aggressively market for customers, just as health plans currently do for federal workers during open enrollment. And the plans would figure out how to make their products distinctive, understandable, and affordable to gain subscribers.

Sue Blevins, president of the Institute for Health Freedom in Washington, spoke at lunch, tackling the important issue of the federal medical privacy rule.

Boston

Then it was on to Boston, for the Harvard Conference on Strategic Issues in American Health Care. (I'm saving my name tag with the Harvard insignia and the "Faculty" ribbon below my name, along with my speaker badge from earlier this year at the London School of Economics, arranged by CIVITAS in London.)

Jeff Goldsmith, president of Health Futures Inc., gave the keynote speech at the Harvard conference about the innovative idea of actually engaging consumers in the decision-making process about their health care. He suggested bureaucratic structures are breaking down as it becomes more and more difficult to please everyone through a centralized decision-making system. Eureka!

Interesting facts: Goldsmith says Humana covers five million people through its various health plans. How many different health plans does Humana offer? 100,000!

Greg Scandlen, the authority on defined contributions, hosted a morning session to help health plan administrators, doctors, and hospital executives learn about this next wave in employee benefits.

In the afternoon, I also talked about consumer choice initiatives, including a brief discussion of defined contributions and rollover of unspent balances in Flexible Spending Accounts, plus more detailed discussion of refundable tax credits for the uninsured. If you would like to view my PowerPoint slides, please go to www.galen.org/news/HarvardSchoolofPublicHealth1.ppt.

New York

Then I went east to New York for a briefing about prescription drugs and the Galen Institute's proposal for a Prescription Drug Security Card for Medicare beneficiaries.

One concern about the proposal is that it breaks Medicare's social contract: Benefits should apply equally to all, regardless of income. The PDS Card is universally available, but the program is subsidized for low-income participants.

Will this satisfy the political concerns? I'd like your thoughts. For the latest version of the paper describing the plan, please go to www.galen.org/news/102601.html.

While in New York, I took a taxi to the Empire State building, where the observation deck has just reopened. It was late afternoon, cold and windy with a drizzle just beginning. Ground Zero is about 30 blocks south, too far to see anything but the hole in the sky where the Twin Towers should have been and the smoke still rising from the ashes. There are two strobe lights somehow elevated to show where the buildings were.

New York felt like a city collectively holding its breath, with President Bush in town for the World Series and Michael Jordan playing at Madison Square Garden with the Wizards. There had been a bomb scare at the adjacent Penn Station and fire trucks, police cars, police dogs, and uniformed officers were everywhere. But the city was safe, and New Yorkers are remarkably resilient and brave in going about life as normal. This still is the world's most vibrant and exciting city.

Sundance

I'm writing from a wonderful mountain cabin in Sundance, Utah, outside Salt Lake City, at the foot of snow-capped mountains for the Health Sector Assembly sponsored by the AMA, Pfizer, Johnson & Johnson, Amgen, and Purdue Pharma.

About 60 health care leaders will talk about the implications of terrorist attacks on the health care system and work to find common ground on aging and chronic care. More later.

Grace-Marie Turner

The Galen Report is a monthly review of health policy matters provided by the Galen Institute, PO Box 19080, Alexandria, VA, 22320, Web site www.galen.org. Grace-Marie Turner is president. The report is complied by editor Elizabeth Lamirand, who can be contacted at 703/299-9550.

RECENT PUBLICATIONS

Economic Stimulus and the President's Proposals for Unemployment Relief and Additional Tax Cuts

Jeff Lemieux
Progressive Policy Institute

The best economic message that official Washington can transmit is its absolute seriousness about protecting America and a commitment to sound, effective government. Lemieux says any economic stimulus should come from improvements in the traditional recession-fighting policy of the federal government: unemployment relief.

He argues Congress should focus on helping workers maintain their health benefits and ensuring that as many unemployed workers as possible receive some benefits and training. "That will boost confidence more than a hastily constructed package of emergency tax cuts," he concludes.
www.ppionline.org/ppi_ci.cfm?knlgAreaID=125&subsecid=162&contentid=3844

The Private Sector's Quick Response to Bioterrorism

Grace-Marie Turner
Galen Institute 10/24/01

As the anthrax scare has exploded over the past week, modern technology's solutions have emerged like a quick strike force. Medical treatment was instantly available with the antibiotic, Cipro. The manufacturer, Bayer Corporation, is ramping up production to produce 200 million doses in three months. And now, new technologies are being offered to the U.S. Postal Service to sanitize and kill anthrax or other bacteria before the mail is sorted, delivered, or opened. If the government were to steal these companies' intellectual property, what possible incentive would they have to continue to make such an investment for the future so they can be ready to respond to the next threat? It is clearly in all of our interest that the government respect the rules of play so the private sector can continue to be a vital partner in the war against terrorism.

See page 14 of this issue of *Health Care News*, or find the article on the Galen Institute Web site at www.galen.org/news/102301.html

Rx for a Healthy Drug Industry

Laura Dykes
Pacific Research Institute, 10/31/01

Dykes analyzes the consequences of government attempts to micromanage the pharmaceutical industry both in the United States and abroad. The conclusion: "Government meddling has been shown again and again to reduce innovation and patient access and to increase government spending."

She warns heavy-handed congressional action in the U.S. threatens to discourage pharmaceutical companies from developing new treatments for anthrax and other bioterrorism threats. Now more than ever, government must not discourage pharmaceutical research and development.
www.pacificresearch.org/

LICENSED TO UNZ.ORG
ELECTRONIC REPRODUCTION PROHIBITED

Tennessee Governor Don Sundquist faces serious challenges as he works to revamp the state's TennCare Medicaid program.

More Trouble Ahead for TennCare

BY CONRAD F. MEIER

In November, Tennessee officials shifted 279,000 members of Access MedPLUS, the largest health plan in the troubled TennCare system, into a plan operated by BlueCross BlueShield of Tennessee.

The state Department of Insurance seized control of Access MedPLUS after the health plan abruptly fired 300 employees without notice or severance pay, according to the *Memphis Commercial Appeal*. The state originally had planned to shift Access MedPLUS beneficiaries to BCBS's TennCare Select after the Access MedPLUS contract with the state expired on January 1, 2002.

Care Won't Be Interrupted

"We would have preferred not to do it this way. But we were getting calls from members saying they could not get services," TennCare Director Mark Reynolds told the media. He said all state providers of health and medical services will accept Access MedPLUS member cards and approvals for services.

According to a report in the *Nashville Tennessean*, the state will allow Access MedPLUS members to visit their usual doctors for four months, regardless of whether those doctors participate in the TennCare Select network.

Reynolds said most primary care providers in the Access MedPLUS network also serve TennCare Select members. The state will reimburse providers who serve Access MedPLUS members based on TennCare Select rates.

More Trouble Ahead?

State officials have said little about Access MedPLUS's financial status. The state won a court order to take over the health plan's operations after financial reports indicated it was insolvent.

The *Commercial Appeal* reports "there is little left to salvage" after Access MedPLUS lost its $39 million-per-month TennCare contract, which provided 99 percent of the health plan's revenues. The plan has more than $54 million in debt.

Thomas Kinser, president and CEO of BlueCross BlueShield of Tennessee, emphasized his firm's commitment to TennCare, but added the state's Medicaid managed care program needs an "overhaul" and increased funding.

In an interview with the *Nashville Tennessean*, Kinser said the state needs to "make market forces work in better ways than they do now" to increase the viability of the program and ensure the participation of managed care organizations.

Noting the size of TennCare, which provides "comprehensive benefits" to roughly 1.5 million people, Kinser said the state should bring into "balance the number of people covered and the way you pay providers and the delivery mechanisms of competing HMOs."

> **"Access MedPLUS lost its $39 million-per-month TennCare contract, which provided 99 percent of the health plan's revenues. The plan has more than $54 million in debt."**

He also called for tightening the program's eligibility system by increasing state oversight of enrollees. "TennCare is the program of last resort, but people's statuses change month to month, year to year. There needs to be a discipline, a rigorous review to be sure that the people on there are the right people."

MAINE continued from page 1

string a single-payer system and cost patients in taxes, quality of care, and stress.

"A Collective Obligation"

Dr. Duncan Wright, a member of the Southern Maine Labor Party who helped initiate the signature drive for the resolution earlier this year, called the single-payer system "mutual aid in an industrialized society." Wright told the *Portland Press-Herald*, "It's a collective obligation we have as a society."

"We each hold up a little part of the weight," Wright said. Health care should be a right, he contends, much like the protection citizens get from police, firefighters, and the Coast Guard.

Under a single-payer system, patients need only present a government-issued identification card to see the doctor of their choice, Wright explained. They would no longer pay insurance premiums, but would see higher taxes. How much higher is a question taken up by the state Health Care System and Health Security Board, which will report on the tax implications and other feasibility issues in March.

Wright said a single-payer system would benefit employers and employees alike. The former would no longer have to worry about budgeting for employee insurance costs and could focus on offering more competitive products and services. The latter would benefit because they'd no longer have to worry about losing their insurance coverage if they switched jobs.

By providing preventive care to all patients, Wright said, a single-payer system would improve the general health of its patients and reduce the need for expensive emergency treatment. He contended life expectancy and infant mortality rates are better in many industrialized countries with single-payer systems than in the United States.

Government would run a more efficient health care system than private companies do, Wright claimed, by slashing administrative costs and getting rid of six-digit executive salaries.

Single-Payer a "Death Blow"

Mark Cenci, co-chair of Citizens for Sensible Health Care Choices, predicted a government-controlled system would deliver a "death blow" to the state's economy.

If the state controlled health care, a monopoly would be created, bureaucracy would explode, and taxes would skyrocket. "People will leave, businesses will leave, doctors will leave. It will cause the whole apparatus (the state economy) to fall in the hole," he warned.

Canada has had a single-payer system since the 1960s, Cenci pointed out. That system has resulted in long waiting lists for surgeries and other medical care—even prompting some Canadians to come to the United States for care they must pay for.

While Cenci agreed some Maine residents—particularly the self-employed—are priced out of the health insurance market by high premiums, a government takeover of the health care system is not the solution. Better options, he said, would include pairing medical savings accounts with high-deductible, low-cost catastrophic care insurance. The state should also consider giving up the "meddlesome mandates" that either drive up premium costs or drive out insurance companies.

"Distorted Picture" Likely

NCPA's Scandlen expects the political discussion in Maine to tilt in favor of single-payer in the months ahead.

"The legislative committee is supposed to make recommendations by March 2002. That means there will be a lot of hearings and meetings between now and then. Most Mainers will be pretty busy just keeping warm during this time. That leaves open-field running for the political hacks and academics who are in love with state-run health care. They can easily fill a hearing room, and they tend to be pretty rabid. It provides a distorted picture of what is the view of regular people."

After a decade of ever-increasing regulation, notes Scandlen, there isn't much insurance market left to defend in Maine. "It is down to essentially one health insurer, which makes it easy to switch from a private monopoly to a public one."

"People who support community rating and other regulations should understand they are just stepping down the slippery slope that will lead to nationalized health care," warns Scandlen.

> **"Citizens for Sensible Health Care Choices [notes] government red tape, rationing of services, and under-funding would hamstring a single-payer system and cost patients in taxes, quality of care, and stress."**

"It isn't just health insurance, either. The proponents in Maine are very clear they want single-payer to replace the health components of worker's compensation and auto insurance, as well. If they succeed, a death benefit will not be far behind, making life insurance either irrelevant or illegal.

"The purpose is, frankly, to abolish a private insurance industry in America."

LICENSED TO UNZ.ORG
ELECTRONIC REPRODUCTION PROHIBITED

My Turn

Socialized Medicine at the Back Door

BY CONRAD F. MEIER
MANAGING EDITOR

What's happening in Portland, Maine (see the news story on page 1 and The Pulse, page 3) is not just activists chanting their favorite leftist sound-bites, nor is it the action of "well-intended" people unaware of the "unintended" consequences of their actions. These people know exactly what they are doing.

I am not inclined to think, as some do, that the Maine effort is some sort of "publicity stunt." While the non-binding Portland referendum passed by only a thin margin in the state's largest, most liberal city, the results may have broad implications for the direction of Maine health care when lawmakers reconvene in January.

At the center of the effort is the 26-state National Labor Party and its local affiliate, the Southern Maine Labor Party. In addition, there's the Maine Peoples' Alliance, Portland Democratic Committee, Portland Independent Greens, Consumers for Affordable Health Care, and Maine's AFL-CIO.

All these left-leaning groups are affiliated with national organizations. I fear we are witnessing the first of 50 well-funded "astroturf" campaigns planned and financed at the national level by people with a socialist agenda.

Make no mistake about it, their agenda calls for the elimination of the health insurance industry and the health insurance component of worker's compensation in favor of a government health care monopoly. Once that monopoly is established, I see a natural progression to the elimination of private life insurance, private auto insurance, private mortgage insurance, and private retirement plans.

These private insurance sectors represent individual freedom and consumer power—neither of which exists in a socialized environment.

Dr. Duncan Wright, a member of the Southern Maine Labor Party who helped launch the signature drive for the Maine referendum, called single-payer health care "a collective obligation we have as a society. We each hold up a little part of the weight."

Physicians for a National Health Program (PNHP) has a Web site (www.phnp.org) that features this statement: "Rats and roaches live by competition under the laws of supply and demand."

PNHP views "this [single-payer] campaign as part of social justice in the United States," not just Maine. "PNHP opposes for-profit control, and especially corporate control, of the health system and favors democratic control, public administration, and single-payer financing. PNHP believes this program should be financed by truly progressive taxation."

Moral Hazard in the Buffet Line

Single-payer means government is the insurance company. It doesn't charge "premiums," but instead raises taxes.

Single-payer also means government is the provider for all medical services. This necessarily requires government to control not only the financing, but also who gets what services, the quality of what they get, when they get it, and if they get it. A single-payer system is one big HMO, without the discipline and accountability achieved by competition. Expect it to be as efficient as the U.S. Postal Service, with the compassion of the IRS.

Every day, in every aspect of our lives, we balance cost against quality and convenience. Sometimes we're willing to spend more for something that is high quality or more convenient. At other times, the quality or convenience difference isn't enough to persuade us to pay more.

But when we are insulated from the true cost of something—in this case health care—the money side of the equation becomes much less important. To paraphrase Milton Friedman, nobody spends their own money like they spend someone else's.

At the all-you-can-eat, $5.99 smorgasbord, many of us eat (or leave behind on our plates) more than we would have been willing to pay for. We think we're getting something for nothing. The sucker who had only one helping subsidizes our second or third trip to the buffet.

If over-consumption at the buffet line gets out of hand, the price will eventually go up, or the amount we're permitted to eat may be rationed. The same holds true for health care.

> **"Single-payer . . . requires government to control not only the financing, but also who gets what services, the quality of what they get, when they get it, and if they get it."**

They Just Don't Get It

For physicians, single-payer means working for a single employer—just like the HMO arrangement they already dislike. But some are tempted by the promise of being freed from the burden of setting prices and collecting payments. Something for nothing?

For patients, single-payer means less care, and lower-quality care. After being *assigned* to a physician (no, you can't choose), getting in to see that physician may not be easy—just ask patients enrolled in Medicare or Medicaid. Doctors in single-payer systems around the world complain they can't spend quality time with patients when they have to see 40 or 50 patients a day. Patients' rights? Those laws don't apply to government-run health care.

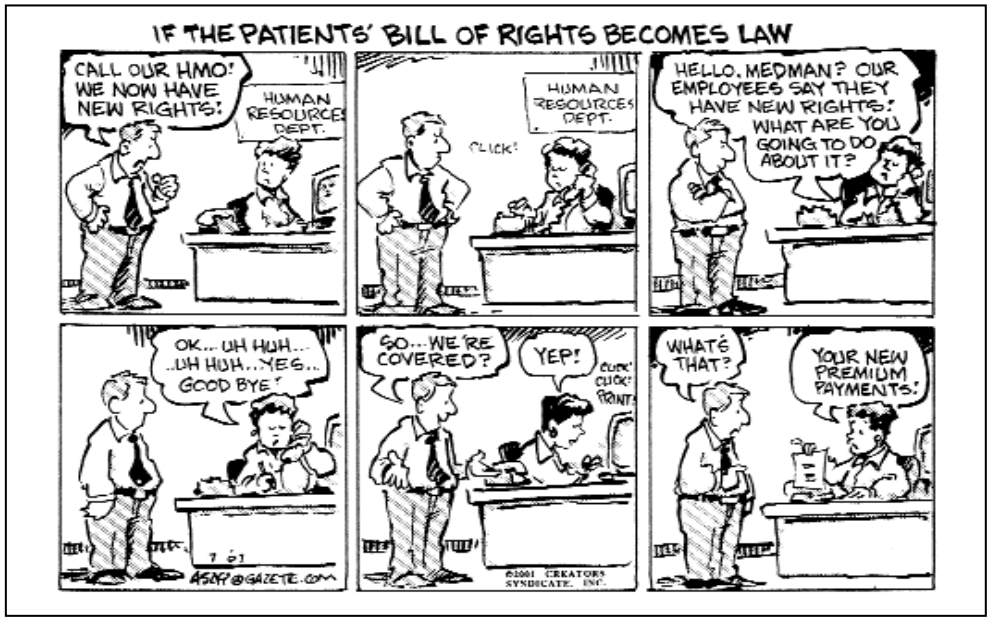
For the politicians, single-payer means being able to promise voters more than the other candidate does. Only later will health care budgets strain under the pressure of increased demand for "free" care. Taxes will have to be increased if services are to be maintained . . . but that will come after the election. State legislators in Tennessee are experiencing the inevitable hangover.

At some point, taxes will be raised as high as taxpayers will stand, and the revenues will still not be enough. Then, the whole system implodes—witness England and Canada . . . or Kentucky, Washington, Colorado, Tennessee, Maryland, and California, all of which have dabbled in single-payer experiments.

Single-payer systems are notorious for passing the buck. Government bureaucrats set the budget, but doctors, hospitals, and other health care providers must make the tough rationing decisions needed to operate within that budget. At the bottom of the pecking order we find the most vulnerable of all populations, patients who require high maintenance and expensive care: seniors and the chronically ill.

Maybe folks in Portland think they are smarter than the collective experience of troubled single-payer plans here and abroad. My advice to folks in the Pine Tree State would be, "be careful of what you ask for, you just might get it."

Or maybe Martin Luther King said it better: "Nothing in the world is more dangerous than a sincere ignorance and conscientious stupidity."


IF THE PATIENTS' BILL OF RIGHTS BECOMES LAW
CALL OUR HMO! WE NOW HAVE NEW RIGHTS!
HUMAN RESOURCES DEPT.
HUMAN RESOURCES DEPT.
CLICK!
HELLO, MEDMAN? OUR EMPLOYEES SAY THEY HAVE NEW RIGHTS! WHAT ARE YOU GOING TO DO ABOUT IT?
OK... UH HUH... ...UH HUH... YES... GOOD BYE.
SO... WE'RE COVERED?
YEP!
CLICK CLICK PRINT
WHAT'S THAT?
YOUR NEW PREMIUM PAYMENTS!
©2001 CREATORS SYNDICATE, INC.

LICENSED TO UNZ.ORG
ELECTRONIC REPRODUCTION PROHIBITED

Attention HIMSS Exhibitors

Make sure your organization gets the attention and booth traffic it deserves!

Advertise in the January issue of HEALTH CARE NEWS

The January issue of *Health Care News* will be available to thousands of attendees at the annual meeting of the Healthcare Information and Management Systems Society (HIMSS) as well as our regular monthly readership of over 13,000.

Health Care News is the nation's premier publication addressing market-based health care reform. There is no other publication like it! *HCN* reaches every state and national elected official, every health care reporter with a major newspaper or magazine, health care professionals, PLUS the thousands of attendees at the conference.

Rates are low - Benefits are high!

Call today for rates*!

Materials Deadline - December 21

Nikki Saret

312.377.4000

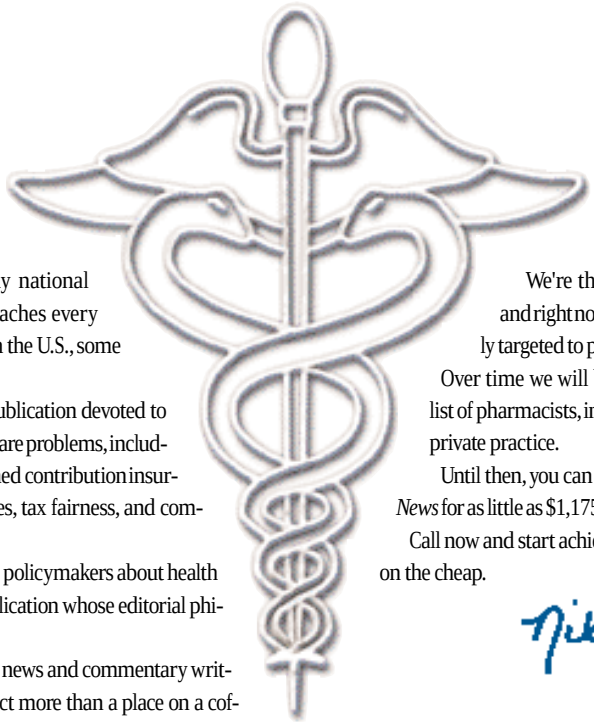
Nikki@heartland.org

**Mention this ad and receive 50% off your 1/2 page or larger ad!*

LICENSED TO UNZ.ORG
ELECTRONIC REPRODUCTION PROHIBITED

Attention Advertisers!

Reach every Governor, every state representative and senator, every U.S. Senator and Congressman...



Health Care News is the only national monthly newspaper that reaches every state and ational elected official in the U.S., some 8,000 key policymakers.

HCN is also the only national publication devoted to market-based solutions to health care problems, including medical savings accounts, defined contribution insurance, repeal of insurance mandates, tax fairness, and competition and choice.

If you want to send a message to policymakers about health care reform, why not do it in a publication whose editorial philosophy is similar to your own?

Elected officials rely on *HCN* for news and commentary written specifically for them. You expect more than a place on a coffee table. *Health Care News* gets read, clipped, copied, and filed.

We're the new publication on the block, and right now our circulation is small but highly targeted to policymakers and opinion leaders. Over time we will build an in-house direct-request list of pharmacists, insurance agents, and physicians in private practice.

Until then, you can buy a half-page ad in *Health Care News* for as little as $1,175 and a full-page ad for just $2,350.

Call now and start achieving your communications goals on the cheap.

Nikki Saret
Publisher
312/377-4000
nikki@heartland.org

...and 500 health care reporters and editors, and 500 talk radio show hosts for as little as $1,175.

LICENSED TO UNZ.ORG
ELECTRONIC REPRODUCTION PROHIBITED